Reimplementation of Bedside Reporting on a Medical/Surgical Unit

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In partial fulfillment of the requirements for the

Doctor of Nursing Practice

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Date of Submission: September 20, 2017

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Abstract

Communication failures during shift change are a leading cause of sentinel events in the United States. The Joint Commission's National Patient Safety Goals are aimed at advocating precise communication among the healthcare team and high-quality, safe patient care. Nurses are instrumental in the achievement and implementation of the objectives. Nurse to nurse communication is essential to ensure that patient outcomes are achieved. The purpose of this project was to create and implement an evidenced-based policy for bedside shift handoff report. The work of Kurt Lewin guided the project in terms of the process of institutional change. PDSA (Plan-Do-Study-Act) functioned as a continuous quality improvement model to inform the development of the implementation and evaluation plans. The project team development implemented and evaluated the continuous quality improvement plan. The project involved education to standardize the flow and process of the handoff report. It was anticipated that education and implementation of a standard handoff report that provides a discussion of the plan of care with accurate information at the bedside, would promote patient and family involvement. Improved nurse-patient communication embraces meaningful aptitude to improve accurate communication to promote positive social change across the institutional service population.

Keywords: *nursing shift reports, shift report, nursing handoffs, handoffs, adverse events, patient safety, bedside handoff, change of shift report, change-of-shift report, nurse handover, shift handover, medical rounds report, medical grand rounds, and patient and family-centered care.*

Re-Implementation of Bedside Reporting on A Medical/Surgical Unit

Introduction

The importance of accurate shift reporting, in the acute care setting, has been an issue for quite some time. This issue is not merely one occurring in the United States, but internationally as well. According to Spinks, Chaboyer, Bucknall, Tbiano, & Whitty (2015), the Australian Commission on Safety and Quality in Healthcare (ACSQH) advocates for bedside shift handover report. This practice allows patients and nurses an active role in the transfer of shift data. The study found barriers similar to the United States barriers. The breakdown in communication was the leading cause of sentinel events reported to The Joint Commission between 1995 and 2006 (Joint Commission Center for Transforming Healthcare, n.d). Of the 25,000 to 30,000 preventable adverse events that led to permanent disability in Australia, 11 percent were due to communication issues, in contrast to 6 percent due to inadequate skill levels of practitioners" (Joint Commission Center for Transforming Healthcare, n.d., para. 5). The Joint Commission had set up a task force to tackle the hand-off communication issues (Joint Commission Center for Transforming Healthcare, 2005). Hand-off communication is now a Standard for Patient-Safety.

Face to face reporting may be done at some facilities, while others prefer a recorded report. The Joint Commissions has concerns about patient safety with hand-off communication because other institutions have implemented bedside communication for hand-off reporting. The subtle changes that happen with the patient's status (especially in critical care) could cause fatal outcomes for patients. In a bedside report, both nurses can listen to the patient and understand if the patient's condition is better or worsening. Bedside report improves patient outcomes and takes time away from the oncoming nurses second-guessing the patient's status.

Problem Statement

Consequences of an insufficient hand-off report, can be, but are not limited to: (1) inappropriate treatment; (2) delay in treatment; (3) minor or major patient harm; (4) lengthened hospital stay; (5) medication errors; (6) omission of orders or procedures; and (7) increased healthcare costs (Braun, 2012). Per National Statistics, 400,000 patients die annually, that is the third-leading cause of death of Americans (Healthcare IT News, n.d.) The loss of patient lives cost hospitals approximately $1 trillion annually (Healthcare IT News). If these trends are allowed to continue, we will continue to have possible preventable loss of life.

Purpose Statement

As floor nurses' hand on their patients to the next shift, there needs to be a standardized way to accomplish this. Literature does not support the audiotaped, written, or spoken face-to-face report at the nurse's station Anderson & Mangino, 2006; Benham-Hutchins & Effken, 2010; Reinbeck & Fitzsimons, 2013). The EBP approach to shift report is taking on a holistic ideal. Creating policy based on EBP for a bedside, rounds report may improve patient outcomes, can improve operational costs, decrease hospital stays, and reduce the chances of some preventable adverse events.

Project Objectives

This project focused on determining what barriers are apparent by this unit concerning performing report at the patient's bedside at shift change. The Joint Commission (TJC) (2007) first addressed the effectiveness of hand-off communication in the 2006 National Patient Safety Goals (NPSG) where an emphasis on providing accurate information that included an opportunity for nurses to respond to questions from fellow nurses and the patient and family members. In 2013, TJC (2013) added bedside shift report as an important practice to keep

patient's, and family members informed for continuity of care and safety. At least three barriers related to bedside report were identified from communication with the unit staff.

A bedside shift report protocol and policy was developed for re-implementation at the site. The outcomes of this project will be shared with the Hospital Leadership to enhance the shift change reporting process on all the Medical and Surgical units. Sharing of this project will assist in obtaining Magnet Status. Additionally, the outcomes will be used to develop nursing training session, in conjunction with educational services, which address the identified barriers to performing bedside shift report and the newly re-implemented policy for BSR.

Population, Intervention, Comparison, Outcome, Time Frame (PICOT) Question

How does the reimplementation of a collaborative, nurse to nurse bedside (rounding) report compare to current practice impact on improving patient outcomes, over an eight-week period?

Literature Review and Theoretical Framework

The Doctor of Nursing (DNP) Project is to create and implement a bedside reporting (BSR) policy, for shift change report. In speaking with educators at eight of the local healthcare systems, five of the systems are currently using BSR, a change from traditional methods of shift change report. One system has a practice built for bedside report, but the practice is not enforced. Of the remaining hospitals, three of the systems used a written report exclusively, and two systems used a face to face report at either the nurse's station or a conference room. The report policies were changed for 6 six of the hospital systems, after The Joint Commission created Goal 13, to incorporate the patient into the shift report for a collaborated treatment plan.

The literature review documents the relevance of BSR including the role of the nurse in length of time for shift reporting, nurse communication, patient, and family-centered care,

adverse effects and medication errors, patient safety, barriers to BSR, the background of BSR, and patient/nurse satisfaction.

The literature search was conducted searching electronic databases, EBSCOhost, PubMed, Medline, Journals@Ovid, CINAHL, and Ovid. The terms used in the searches were *nursing shift reports, shift report, nursing handoffs, handoffs, adverse events, patient safety, bedside handoff, change of shift report, change-of-shift report, nurse handover, shift handover, medical rounds report, medical grand rounds, and patient and family-centered care.*

Early exploration produced 48 articles. Identified literature was cast off if they were not pertinent to the subject selected. To expand the search, Boolean search terms of "or" and "and" were used between search words. A review of the 48 articles determined that 32 items the most pertinent to the project. The following subjects classified all articles: bedside report and accountability, nursing handoff/shift handoff/handover, bedside report and patient safety, adverse effects and medication errors/omissions nurse, and patient satisfaction related to bedside reporting. Additionally, the following barriers to bedside report include BSR background and patient and family-centered care related to bedside report.

Bedside Report Barriers

Confidentiality

Regardless of the Evidence-Based Practice (EBP) that is evident in the nursing literature, nurse's struggle with fully implementing bedside report (BSR) that involves the patient and family (Sand-Jecklin & Sherman, 2013). There is a concern about breaching patient confidentiality with BSR, which is frequently cited in the literature. With the Health Insurance Portability and Accountability Act (HIPAA), nurses are concerned with violations. Patient privacy with shared hospital rooms, with another patient and family members in a patient's room,

is concerning. Unauthorized persons can overhear confidential and private health information are concerning (Cairns, Dudjak, Hoffman, & Lorenz, 2013; Sand-Jecklin & Sherman, 2013; Anderson & Mangino, 2006; Radtke, 2013; Evans, Grunawalt, McClish, Wool, & Friese, 2011; Ofori-Atta, Binienda, & Chalupka, 2015; Reinbeck & Fitzsimons, 2013). Nurses not only report concerns about confidentiality, but discussing sensitive family dynamics, test and lab results they primary caregiver has yet to discuss with the patient, and discussing noncompliance regarding treatment plans with the patient (Cairns et al., 2013).

Length of Time

Nurses also express a time commitment to report as a barrier; there is restricted literature that examines the duration of time spent with traditional shift report methods and the time spent with BSR. Cairns et al. (2013) report and decreased the length of time in shift report of approximately 10 minutes per day, a total of 61 hours a year, representative of a 23% cost savings for the unit budget. Anderson and Mangino (2006) referenced an overall decrease of 100 hours of overtime per pay period, over two consecutive pay periods. Caruso (2007) states specific time reduction to an average of 5-7 minutes for BSR, which is considerably less than the pre-implementation oral report, which occurred at the nurse's station or conference room. Tidwell et al. (2011) discuss a decrease of 250 hours of overtime over a seven-month period after implementing BSR.

In most cases nurses are concerned that the patient and family will consume too much of the nurse's time with questions, talking or by asking for something during the report. Nurses believe considerable length will be added to shift report if BSR is used (Anderson & Mangino, 2006; Sand-Jecklin & Sherman, 2013; Evans et al., 2011). The nurses believe that frequent

interruptions and nurses were chatting with patients and families as barriers to BSR (Novak & Fairchild, 2012; Street et al., 2011).

Inconsistent Quality

 Nurses (50%) have stated concerns with the quality of BSR. Quality problems include the consistency of the information being relayed, the relevance of the shared information, and omitted information (Welsh, Flannagen, & Ebright, 2010). The nurses also stated an issue with being able to ask clarifying questions to the vague information presented. (Welsh et al., 2010). Nurses are concerned with the lack of standardization in BSR (Braun, 2012). The literature suggests implementing a review of the Electronic Medical Record (EHR) and a standardized structure for BSR such as Situation, Background, Assessment, and Evaluation (SBAR) (Braun, 2012).

Nurse Shift Reporting

Nurse Communication

The shift-change report can take many forms. A qualitative study conducted by Welsh, Flanagan, and Ebright (2010), categorized change-of-shift report into two styles of handoff, written and taped. The literature states that traditional methods of shift report are not sufficient. These methods only allow insignificant communication between the shift nurse's and have an undesirable impression of patient safety about imperfect information being conveyed between caregivers (Welsh et al., 2010; Anderson & Mangino, 2006; Benham-Hutchins & Effken, 2010; Reinbeck & Fitzsimons, 2013).

Timely and accurate patient information must be communicated, it is vital in delivering quality and safe patient care, guaranteeing stability in all patient's care. Caruso (2007) designated shift reports as a time for focused communications regarding the continuity of care

and patient safety, yet this type of communication rarely occurs. "Approximately 2.9 million shift-change reports occur annually in hospitals with an average daily census of 400 patients and nurses working 12-hour shift" (Halm, 2013 p. 159). Contributing to the errors are treatment delays, care omissions, and adverse events. Additionally, avoidable readmissions, inappropriate treatment, increased cost, repeated work, and repeated work, are noted with frequent transfers of patient data (Halm, 2013; Cairns et al., 2013; Jeffs et al., 2013; Anderson & Mangino, 2006; Riesenberg, Leitzsch, & Cunningham, 2010).

Adverse Events and Potential for Errors

 Inconsistency with the method used for shift report is completed, could initiate errors or potential adverse events (Riesenberg et al., 2010). Three simulated scenarios tested three shift change report styles; verbal only, written only, and a combination of written and oral (Pothier, Monteiro, Mooktiar, & Shaw, 2005). Pothier et al., (2010), recounted that the nurses recalled more patient data with a blend of verbal and written report (96-100%), oral only (0-22%), and written only (26-49%). Despite the method of the report used, weakness and strengths are integral to all methods of the report (Friesen, White, & Byers, 2008). Tens of thousands of patients are cared for in acute care facilities each day, which opens nurses up to tens of thousands of chances for errors, with the transfer of patient data (Baker, 2010).

<div align="center">**Moving Towards Bedside Reporting**</div>

 Conventional methods (taped, written, or verbal at the nurse's station) for shift reporting do not allocate the patient or family to participate in this transfer of information. Propelling forces have led nursing to turn to a move in the patient report to the patient's bedside (Anderson & Mangino, 2006). The ease of internet access for the patient to research healthcare information that they were not formerly aware, giving them more awareness to make healthcare choices. Healthcare

information and education have triggered a conversion to a collaborative paradigm of care

involving the patient and family into assisting with health care decisions and treatment plans

(Anderson & Mangino, 2006; Evans et al., 2011; Novak & Fairchild, 2012; Maxson, Derby,

Wrobleski, & Foss, 2012). Patients given the prospect to partake in a BSR, they are more

inclined to contributed to healthcare decisions about their treatment plan and sought

opportunities for education about their care and diagnosis (Maxson et al., 2012; Anderson &

Mangino, 2006).

Background of Bedside Reporting

 Nursing Shift Report has by tradition occurred away from (nurse's stations and conference

rooms). The patient's bedside, where the patient's family and the patient are not participating

actively in the share of patient data had not occurred previously (Maxson et al., 2012; Anderson

& Mangino, 2006; Braun, 2012; Kerr, Lu, & McKinlay, 2013). Today, patients are more actively

immersed into the general approach to healthcare where the patient is included into healthcare

plan of care and treatment plans (McMurray, Chaboyer, Wallis, & Fetherston, 2010). Many

hospitals nationwide are researching evidence-based practice with the intentions to redesign

nursing shift report to meet the standards proposed by The Joint Commission (TJC) (Welsh et

al., 2010). The goal of BSR is not necessarily to visualize the patient but to encourage

participation between the nurses and the patient and family to discuss the patient's treatment plan

(Maxson et al., 2012).

There is a broad range of methods for communicating shift change report. The patient

care, accountability, and responsibility change from one nurse to another nurse, at shift change,

needs to be consistent. A breakdown of consistency leads to an increase of risk for incorrect or

missing patient information, ultimately endangering patient safety (Alvarado et al., 2006). Shift

change report has been referred to as overlong with extraneous information, and other

descriptions are systematic and timely (Street et al., 2011).

Bedside report is not a new concept. At the beginning of the 20th century, "Ward sisters

in England would make rounds with the night nurse on each of the patients to check that

standards of care were met through the night" (Greaves, 1999, p. 32). In the literature review,

Pepper (1978), issue a challenge to leave behind anecdotal shift change report that occurs at the

nurse's station or a conference room. The benefit of BSR is the capability of the nurses to

incorporate the patient and family into the treatment plan (Pepper, 1978). Per Pepper, "this

patient-centered approach to shift report should be accomplished every change; otherwise, the

patient may perceive this as just a daily "exercise" by the nursing staff" (p. 74).

Nurse and Patient Satisfaction

Bedside report assists with several purposes beyond the transmission of critical patient

data, two of which are the nurse and patient satisfaction. The standardization of BSR can

positively influence patient satisfaction of care provided. A study by Radtke (2013) identified

standardization of shift report to BSR improved patient satisfaction, especially with nursing

communication. Radtke (2013) stated that before BSR patient satisfaction was 75%. After BSR

was implemented on a 16-bed medical/surgical care unit, the patient satisfaction scores improved

to 87.6% (Radtke, 2013).

 Nurses and patients recognize the benefits of BSR. A study showed an increase in patient

satisfaction with the use of BSR and created an insight into collaboration and teamwork (Maxson

et al., 2012). The study by Maxson et al. (2012), identified a second determination of BSR, and

that is increased nurse satisfaction with accountability and communication. Patients and staff

agreed to partake in surveys that were given before and after implementation of BSR.

Statistically, noteworthy increases in nurses' opinion regarding accountability (p=0.0005) ability to communicated concerns (p=0.008), and medication reconciliation (p=0.0003), and patient perception of the plan of care (p=0.02) (Maxson et al., 2012). Additionally, anecdotal reactions from the nurses and patients validated the importance of a change to BSR (Maxson et al., 2012).

Patient and Family-Centered Care

A sizable emphasis of literature on patient and family-centered care has been identified. Evolving partnerships with providers and nurses and collaboration with the patient and family members to create a plan of care are evident in the literature (Brownjohn et al., 2016; Sand-Jecklin & Sherman, 2013; Gregory, Tan, & Tilrico, 2014; Maxson et al., 2012; Laws & Amato, 2010). Nurses can assist with collaboration between patients and family with BSR (Tidwell et al., 2011). By providing the report at the bedside, the patient and family can participate in the healthcare decision-making process, treatment plan, and education, thus improving the patient's experience (Griffin, 2010).

Patients have identified numerous benefits of BSR. In a pilot study researching patient opinions of BSR by Friesen, Herbst, Turner, Speroni, & Robinson, (2013), patients were interviewed and surveyed to identify impending areas for enhancement of BSR. The researchers have identified five subjects. First, an introduction of the new oncoming nurse allowed them to feel comforted (Friesen et al., 2013). Second, patients witnessed the collaboration and communication between coworkers with BSR (Friesen et al., 2013). Third, sharing patient data at the bedside allowed the patients to know what was discussed regarding their care (Friesen et al., 2013). Fourth, patients were educators about what they need for the BSR, such as information written on a whiteboard (Friesen et al., 2013). Moreover, fifth, privacy is hard to maintain with hard-of-hearing (HOH) patients (Friesen et al., 2013).

Lewin's Change Model

Kurt Lewin developed the Change Model or Theory of Nursing. He developed a three-stage model of change known as a unfreezing-change-refreezing model that requires all prior learning to be rejected and replaced (Lewin, 1951). Lewin's definition of behavior in this model is "a dynamic balance of forces working in opposing directions."

The three concepts that have been identified in Lewin's Change Theory are driving forces, restraining forces, and equilibrium. Driving forces are forces that shove in a direction that causes the change to ensure (Lewin, 1951). Equilibrium is a state of being where driving forces equal restraining forces, and no change happens (Lewin, 1951). Restraining forces are those forces that oppose the driving forces (Lewin, 1951). Restraining forces cause a shift in equilibrium for the change.

Driving forces aid change because they drive the person in the desired direction towards the change. These forces cause a modification in the equilibrium, of the person's learned responses, towards change. The driving forces hamper change because the individual is pushed in the opposite direction of the learned responses. Driving forces cause a shift in the equilibrium which contradicts change. Equilibrium can be raised or lowered by changes that occur between the driving and restraining forces; but can equal the restraining forces and then no change can happen (Kritsonis, 2005).

Unfreezing is the process which involves finding a technique of making it possible for people to relinquish an old model that was somehow counterproductive. It is necessary to overpower the pressures the individual struggle with and cause the person towards the group submission. Three methods can direct the success of unfreezing. The first is to increase the driving forces that direct behavior away from the status quo. Second, reduce the restraining

forces that adversely affect the movement from the current equilibrium. Thirdly, finding a combination of the driving forces and the restraining forces to promote the change (Zaccagnini & White, 2011).

Identifying what needs to be changed by looking at the organization and understanding what is the current procedure. Understand why a change needs to be made. Researching evidence-based practice is essential to making a sound case to the need to change. Use of stakeholder management or stakeholder analysis to identify and earn the support of key members of the organization can be useful to make an organization-wide change (Zaccagnini & White, 2011).

The next step in the freezing model is creating a strong point as to why the change must occur. Emphasize the EBP and the reasons "why" the change is required. Understand the employee's concerns and doubt about the change (Zaccagnini & White, 2011).

"The change stage, which is also called "moving to a new level" or "movement," involves a process of change in thoughts, feeling, behavior, or all three, that is in some way more redeeming or more productive" (Manchester et al., 2014, p. 85). Tin order to facilitate the changing stage, communication is essential. Explaining the stages of planning and implementing the change; prepare staff for what is coming; tell how the change will affect them, and explain the benefits of the change. Dispelling rumors by dealing with the problems immediately; openly and honestly answer questions, and explain why the change must occur for the favor of operational necessities. Involve staff in the process of the change; have frontline managers provide the day-to-day direction of the change, and consult with external stakeholders as needed for the change.

The refreezing stage is creating the change as the new routine so that it now becomes the "standard operating procedure." Without this final stage, it can be easy for the staff to go back to old habits (Zaccagnini & White, 2011). To assist with the refreezing stage, identify barriers to maintaining the change and determine what factors support the change. Develop ways to manage the change, by guaranteeing leadership support; create a compensation system; creating a feedback system, and adapt the organizational structure if needed. Provide support and training and keep staff and stakeholders informed.

The use of Lewin's model provides a fundamental framework for education and implementation success as it related to a recounting process (Olson-Sitki, Weitzel, & Glisson, 2013). Lewin's model presents a chosen change to in individuals and an organization. The change can occur because of driving forces in the direction of the change or weaken opposing forces over a series of the three phases unfreezing, change, and refreezing (Zaccagnini & White, 2011). Olsen-Sitki et al. (2013) examine a similar situation, within several months of the change to the bedside report, the report was occurring in a conference room, in the hallway, or at the nurses' station instead of at the patient's bedside as initially implemented. In the study, report of the oncoming nurse was regularly done, but there was no patient collaboration. The nursing leadership became aware that the new procedure did not become part of the culture as intended (Olson-Sitki et al., 2013). Thus, the freezing, change, refreezing model broke down because the stakeholders were not invested. Appropriate supervision, training, and communication did not occur.

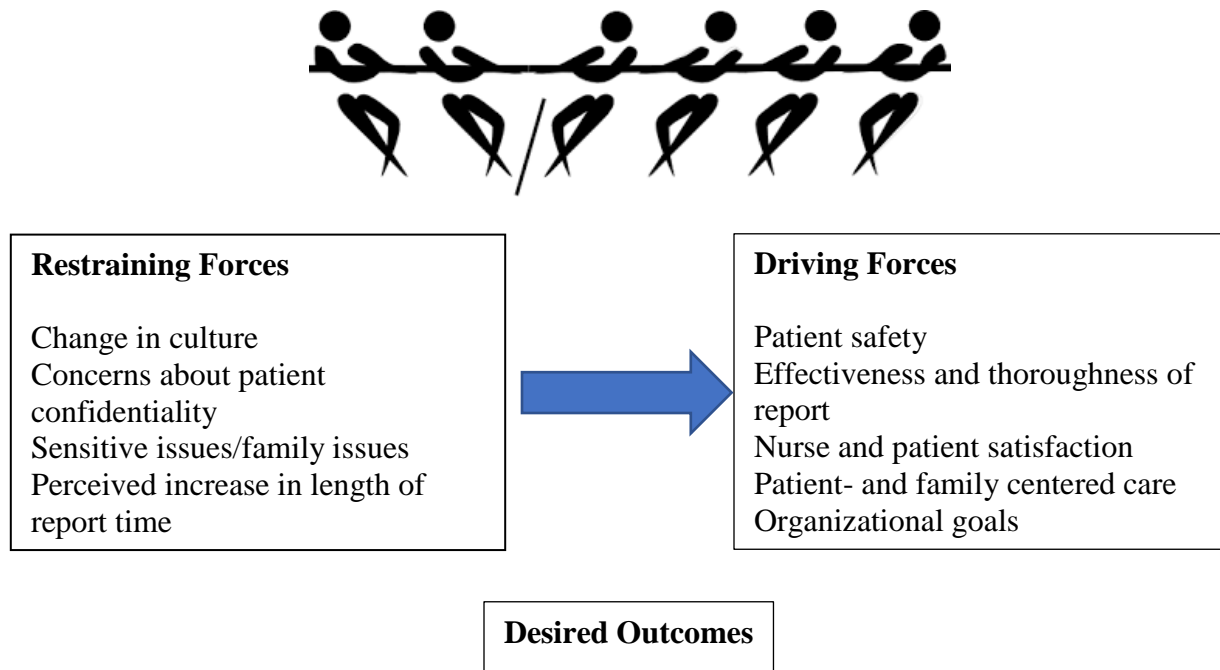| Restraining Forces	Driving Forces
Change in culture Concerns about patient confidentiality Sensitive issues/family issues Perceived increase in length of report time	Patient safety Effectiveness and thoroughness of report Nurse and patient satisfaction Patient- and family centered care Organizational goals

Desired Outcomes

Figure 1. Lewin's model depicted as tug-of-war. The strength of the driving forces must overcome the restraining forces to reach the desired outcome (Lewin, 1947, p. 32). Restraining and driving forces adapted from; Anderson & Mangino, 2006; Alvarado, et al., 2006; Baker, 2010; Cairns et al., 2013; Caruso, 2007; Evans et al., 2012; Halm, 2013; Jeffs et al., 2013; Maxson et al., 2011; Radtke, 2013; Riesenberg et al., 2010; Sand Jecklin & Sherman; Street et al., 2010; Tidwell, 2011; Vines et al., 2014; and Welsh et al., 2010). Image: Tug of War Long Clip Art. (2014)

Conclusion

 The literature supports a transition from anecdotal shift report to a bedside report method; BSR can enhance teamwork and the accountability of shift change communication and care, of the nursing staff. The Joint Commission's National Patient Safety Goals (Joint Commission Center for Transforming Healthcare, 2005), comprising Goal 13: to involve the patient in their care as a strategy to improve patient safety (Baker, 2010); (Klee, Latta, Davis-Kirsch, & Pecchia, 2012). Many hospital systems have been searching the literature to develop a shift communication that can meet Goal 13. Patient and nurse satisfaction is enhanced, also with the patient and family-centered care. BSR can decrease errors and complications that can be eliminated compared with

traditional reporting methods. Lewin's Change Theory is the appropriate framework for the

project. Change must be implemented in the institution for successful implementation.

Project Timeline, Ethics and Human Subjects, Plan for Analysis and Evaluation,

and Implications for Nursing

Description of Project Design

The purpose of this project was to identify the barriers that cause the nurses on a

Medical-Surgical unit to follow organizational practices for bedside report (BSR). Also, this

project offered educational insights as to barriers in re-implementing BSR and assisting the

organization is achieving Magnet Accreditation. An analysis of collected information was used

to design an informative program to improve the nursing staff's attitude in performing BSR. This

evidence-based practice project focused on activities involved in this process and refined the

current practice policy.

Implementing any practice change can be a challenge in any field, including nursing.

According to Wallis (2012), change can be encumbered by numerous dynamics such as

organizational or unit culture, behaviors and practices that are challenging to adapt, and lack of

time. A leader or manager must have buy-in for the change and acknowledge the significance of

it.

Population of Interest

The nursing staff on a Medical-Surgical unit at a Midwestern hospital was the focus of

this project. The hospital had a practice policy in place for BSR. This policy is not being

followed at before the implementation of the new policy based on this project. In observing the

nurses and their report methods, it had been noticed that the newer nurses on the unit are more

compliant in implementing the practice policy, but several were being negatively influenced by

nurses with several years' experience on the unit. This negative impact had been seen by the unit

management but had not been addressed. The senior nursing staff had been giving and receiving

shift report at the nurse's station by refusing to follow practice policy. Unfortunately, the senior

nurses were influencing the novice nurses in disregarding the policy.

Setting

The setting for the study was on a Medical-Surgical Unit in a hospital system located in

the Midwestern portion of the U.S. This unit serves veterans ranging in age from 18 to 100+

years old, in private patient rooms.

Stakeholders

The nurses that perform the BSR and the leadership that propelled it was the focus of the

project. For a project to be fruitful, there needs to be buy-in from key stakeholders. According to

Portoghese et al. (2012), key stakeholders are those that are influenced by policy

implementation. The key stakeholders and nurses need evidence of the reasons why to change to

BSR. "Providing evidence of outcomes that support the change can help increase the nurse's

commitment to the process" (Portoghese et al., 2012, p. 585).

The hospital is currently seeking Magnet Accreditation. Through the process of

accreditation, the hospital leadership has a vested interest in the success of this project. The

Magnet Committee is made up of crucial stakeholders of the Chief Nursing Officer, organization

directors, managers, clinical specialists, clinical nurse specialists, staff nurses, and charge nurses.

I have been included in the Magnet Committee to help facilitate the reimplementation of BSR.

A project team of stakeholders was formed to design and implement the evidence-based

practice project. According to Kelly (2011), successful teams are not just designed but also

developed. The Magnet Accreditation Committee was optimal for the project team. Team

members were requested to contribute to the project because of their aptitude, expertise, and

interest in seeing this project progress within the organization. Medical-Surgical nurses were observed during BSR to provide perception into the barriers to BSR not occurring as expected at the bedside. The project team members and their position include the following:

1. I will function as the project leader and group facilitator.

2. Full-time and part-time day-, evening-, and night-shift medical-surgical nurses.

3. Chief Nursing Officer (CNO)

4. Clinical leadership team (CLT) comprised of Magnet Accreditation Committee members

5. Director of Nursing Education and Professional Development

6. My project mentor

7. Anonymous nurse observers

Recruitment Methods

Any approaches used to re-introduce BSR could be very individualized contingent not only on the unit or facility but on the culture of change and acceptance. According to Burke & McLaughlin (2013), to encourage BSR, nurse leaders recognized the potential benefits of BSR. A portion of the procedures used was to acknowledge the importance of being transformational leaders. During this leadership process, individuals were asked what their opinions are for encompassing BSR, ways of standardizing the process of how BSR training and education should be set up, how it should be reviewed, and how the implementation and evaluation plans ought to be launched (Burke & McLaughlin, 2013).

A flyer was posted in the restrooms, inside the unit break room, on the outside of the break room door, in the locker rooms, and at each of the nursing stations on the medical-surgical unit. The flyer discussed the need to reimplementation of BSR for Magnet Accreditation. Two

anonymous observers from each shift were needed to assist with the implementation process. Prospective observers were chosen by the Unit Manager. These observers are charge nurses and unit educators.

Tools/Instrumentation

The standardized tool Clinical Evaluation Exercise (CEX), developed off the mini-CEX that measures the quality of history and physical examination, consists of seven fields scored on a 1-9 scale (Horwitz et al., 2013). Validation studies have previously been conducted for the mini-CEX, that identified this tool a valid and reliable. The Spearman rank correlation coefficients ranged between 0.71 to 0.86 (Horwitz et al., 2013), 0.80 to 0.86 (Berkenstadt et al., 2008), and 0.84 to 1.00 (Faran et al., 2010). All of the correlation was significant at $P<0.001$. Kappa scores range between .028 (95% CI: 0.38, 0.80) (Horwitz et al., 2013), 0.43 (95% CI: 0.29, 0.58) (Berkenstadt et al., 2008), and 0.38 (95% CI: 0.25, 0.51) (Faran et al., 2010). A clinical nurse educator observed shift-to-shift BSR among nurses and evaluated both the recipient and provider of the report. The nurses partaking in the report concurrently evaluated each other as part of their handoff (Horwitz et al., 2013). See Appendix A.

A study by Horowitz et al. (2013), have determined the CEX tool is easy for nurses to use with very little training. The tool performed in the same way in other institutions (Nestel, Kneebone, & Barnet, 2005; Lyons, Standley, & Gupta, 2010). In another study by Horwitz et al. (2013), the tool was determined to be easy to use and was well accepted by participants. The tool did allow for an opportunity for the evaluators to ascertain systems failures with the handoff procedure (Horowitz et al., 2013).

The CEX tool was used in this project for staff education for the implementation phase of the project. Identifying what works and what does not are important for a successful application. What all of this research shows is:
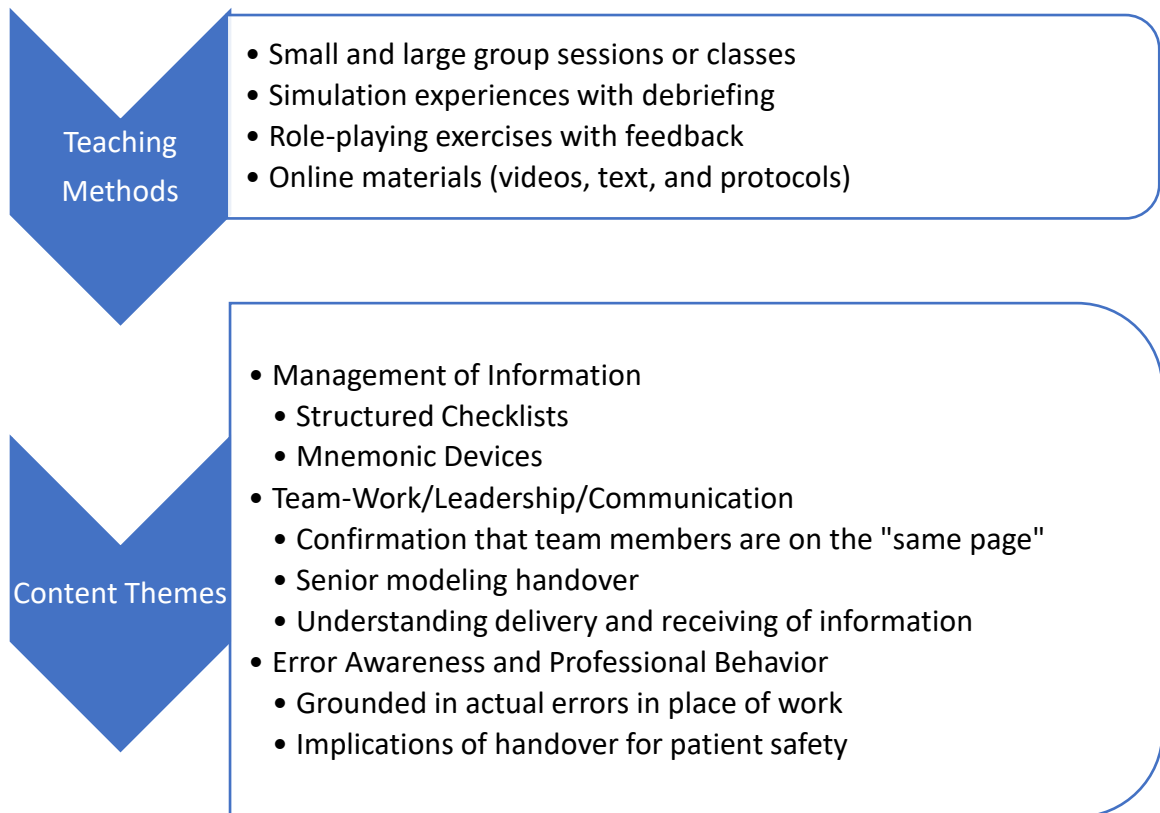
Teaching Methods
- Small and large group sessions or classes
- Simulation experiences with debriefing
- Role-playing exercises with feedback
- Online materials (videos, text, and protocols)

Content Themes
- Management of Information
  - Structured Checklists
  - Mnemonic Devices
- Team-Work/Leadership/Communication
  - Confirmation that team members are on the "same page"
  - Senior modeling handover
  - Understanding delivery and receiving of information
- Error Awareness and Professional Behavior
  - Grounded in actual errors in place of work
  - Implications of handover for patient safety

Figure 2.

"Quality improvement (QI) methods have been introduced to healthcare to support the delivery of care that is safe, timely, effective, efficient, equitable and cost-effective" (Reed & Card, 2016, p. 147). One tool in QI is the Plan-Do-Study-Act (PDSA) cycle. The PDSA cycle was originally developed by Walter A. Shewhart and offers a well-thought-out investigational learning approach to testing changes (Simon & Canacari, 2012). The purpose of the PDSA cycle is learning as quickly as possible whether the intervention works, then making any necessary adjustments.
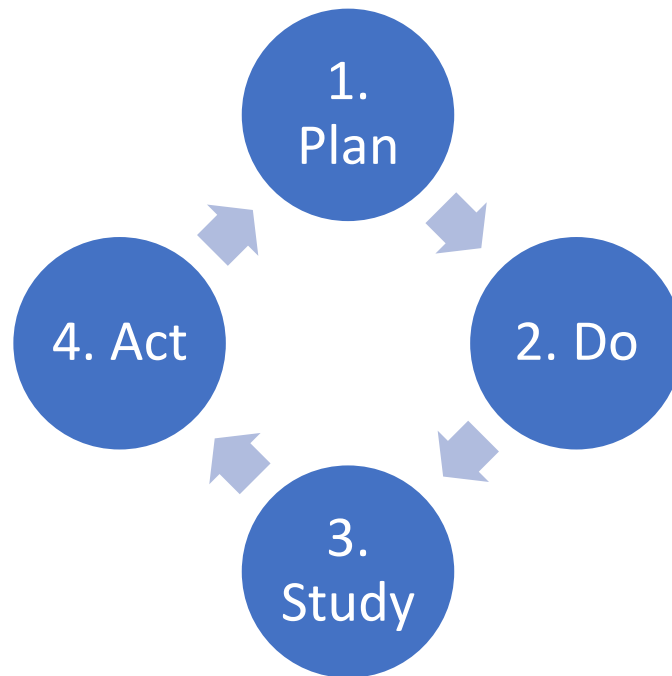
Figure 3. (Moule, Evans, & Pollard, 2013, p. 594)

In a study by Moule, Evans, & Pollard (2013), for effective use of the PDSA cycle,

stakeholders need to be educated on the tool. In another study by (Ragsdale & Mueller, 2005),

showed improved employee retention with the implementation of the PDSA cycle for employee

orientation.

The PDSA cycle was used as a tool for the reimplementation of the BSR practice policy.

The theory is suitable in that the tool ties barriers with defining, tracking, and evaluating the

change (Cairns, Dudjak, Hoffman, & Lorenz, 2013). This improvement model's underpinning is

based on doing the right thing every time for the patient (Agency for Healthcare Research and

Quality, 2013; Cairns et al., 2013). According to Simon & Canacari (2012), this four-step cycle

or model for carrying out change is: Plan-recognize an opportunity, plan a change, and estimate

the impact of the planned change. Do- test the change; carry out a small-scale study. Check -

review the test results and identify what you have learned. Act - take action based on what is

learned in the study; if the change did not work, repeat the cycle with a different plan; if the

change is successful, incorporate what is learned from the test into the work process used in the

area (p. 87). PDSA cycle is repeated over and over to improve the process continuously.

The PDSA cycle validity has been documented in many resources. The Spearman

Correlation Coefficients ranged between 0.40 to 0.80 (Reed & Card, 2016), and 0.39 to 0.71

(Moule et al., 2013). The kappa scores for reliability were 0.50 (95% CI: 0.36, 0.4) (Reed &

Card, 2016) and 0.45 (95% CI: 0.24, 0.67) (Moule et al., 2013). "The PDSA cycle is more

insistent on collecting and analyzing data throughout the process, as well as designing a

measurement system to assess the progress from the current approach to whatever plan or

solution eventuates" (Cleary, 2015, p. 22).

Data Collection Procedures

Data collection is a significant element of the project. The CEX tool will be used before

implementation. The collection period will take approximately 1 to 2 weeks. After this time

frame, data collected from the completed CEX forms will be compiled into a table

to determine evidence of inconsistencies and inaccuracy of shift report at the nurse's station. The

data received will be examined and used to develop a pre-implementation education plan using

the PDSA Cycle model.

Additional baseline data will need anonymous observers (approved by the unit manager)

using a simple checklist to observe all three shifts for five days each shift. The baseline data will

include:

1. Both nurses at the bedside

2. Not at the bedside, where did the nurses give report

3. Not at the bedside, ask the nurses "why not."

The "why not" data will be used to develop educational workshops on barriers to bedside report

will be completed then the above data will be reevaluated:

1. One month later observe using the same checklist

2. Re-evaluate to see if new barriers exist and re-educate staff.

The PDSA cycle model is one of continuous improvement and evaluation. This will be essential

to re-implement the BSR practice policy.

Intervention/Project Timeline

In discussion with the unit manager (Appendix B), she had approved the

reimplementation of Bedside Report (BSR). The manager had allowed her unit to be used as the

pilot site for the reimplementation policy. This reimplementation was also be carefully watched

by the Magnet Designation Committee since this practice policy was not currently being

completed by the nursing staff. This is one practice policy that the Magnet Designation

Evaluators will be looking to carry-out facility-wide (Swanson & Tidwell, 2011). If the re-

implementation is successful, the organization wants this to be the new practice policy for the

unit and will be used facility-wide for all inpatient units. The project is best practices based on

the literature review for EBP about BSR. The new practice policy included the input from the

project team and carried out by the project leader. The new policy requires all shift reports and

transfer reports are completed at the patient's bedside, for the patient to ask questions regarding

their care, and for the shift nurses to see subtle changed in the shared patient.

The new policy is very closely mirrored after the original policy, but the original policy

failed with its implementation. The staff RN's were not supervised by Unit leadership then the

policy was implemented. The new policy, the nurses are supervised by the Unit leadership and

the Education/Professional Development department to ensure compliance, at the

implementation of the new policy and every week for the following six months, then weekly

until the organization deems this is no longer warranted. The unit leadership and educators will

use the PDSA model to evaluate and implement any needed changes to the implementation and

evaluation plan (Moule et al., 2013)

Staff education included how to overcome the barriers to the policy. This education will

be used at orientation for all new Registered Nurse (RN) hires. The educational workshops were

short educational programs designed to communicate barriers to the practice policy, the need to

reimplement the practice policy, and the benefits of re-implementation. A PowerPoint

presentation (Appendix L) was created and shared with all members of the nursing staff on the

Medical-Surgical Unit at mandatory staff meetings for all three shifts, by the team leader. Cairns

et al. (2013) found that didactic education with the use of presentation tools can enhance

learning, provided that resources are shared with participants.

Five days before the education workshops for the reimplementation of BSR, anonymous

observers followed a predetermined checklist for each of the three shifts. The observers received

a 15-minute in-service on the checklist and how to implement it, by the project lead. The unit

manager requested to select the observers that she can trust with accurately documenting the

observations (Charge Nurses and Educators). After the initial checklist had been completed, the

educational workshops were conducted. The time needed to implement the project on the

medical-surgical unit was approximately one month. After which, two weeks' post-

implementation, an evaluation to assess if the goals were met took place. For one week post-

implementation, the same anonymous observers identified if BSR is being completed, with the

same checklist (in compliance with hospital policy) as with the initial assessment the checklist

had no identifying information of the observers or the RNs being observed.

A quality improvement (QI) team was formed with attentive knowledge of the main goal and objects (Kelly, 2011). The QI team was formed by the team leader, unit manager, and the Magnet Committee (organization directors, managers, clinical specialists, clinical nurse specialists, and charge nurses). Implementing a QI project, the team members needed to be supporters of the project and needed to be truly invested in the success of the project (White & Dudley-Brown, 2012). The quality improvement team met for one hour to collaborate and review the projects evaluations. After which time, the project lead re-educated the nursing staff and addressed any additional barriers to the implementation process. The quality improvement team decided a tentative go-live date for the re-implementation for the inpatient unit's system-wide.

The educational workshop will include:

- Evidence-Based Practice handouts on BSR

- The current BSR policy and the proposed changes

- A Bedside Report worksheet (Appendix F and G)

- A PowerPoint presentation

Human Subjects Protection

A handout was delivered to each RNs mailbox on the unit, posted inside the unit break room, and at each of the nursing stations on Medical-Surgical unit. The handout included the reimplementation of BSR objectives and the need for 100% compliance for Magnet Designation. The reimplementation was discussed at monthly staff meetings for each of the three shifts, and at the morning huddles to clarify questions about the reimplementation and objectives. The nursing staff was given a handout, placed in their mailbox, discussing the new policy and the

implementation. The project leader discussed the re-implementation at the monthly staff

meetings and created a handout that was read by the charge nurse at each morning huddle.

All the RNs on the Medical-Surgical unit were educated on the reimplementation of BSR,

and all RNs were included in the anonymous observations. The staff was informed of this at the

time of re-implementation. No names were collected, and all observations/evaluations were kept

in a locked box in the unit manager's office until the time the quality improvement team met two

week's post-implementation. The anonymous observers signed confidentiality agreements, as

well as all members of the quality improvement team. All team members were present to discuss

the implementation process following PDSA tool. The PDSA tool and the surveys were kept in

the education office, in a locked filing cabinet that the Education Director holds the key, after the

evaluation.

Institutional Review Board (IRB)

The necessary paperwork was submitted to Touro University of Nevada (TUN) to obtain

approval and the project site's IRB prior to obtaining participants. The initial contact with the

IRB Coordinator was made, at the project site, prior to the start of the implementation project.

Web-based training modules sponsored by the Collaborative Institutional Training Initiative at

the University of Miami (CITI) was deemed necessary by the IRB at TUN and the School of

Nursing. The participants' names or identifiers were not recorded. But pre-implementation and

post-implementation surveys were kept in the unit manager's office in private and sealed

envelopes. The surveys were collected by the project leader daily. The major themes on the

surveys were shared with the unit after the QI teams met.

Plan for Analysis/Evaluation

The project evaluation plan for the project facility was conducted on the Medical-Surgical

Unit. The reference point of data was measured for 5 days on each of the three shift changes by

an anonymous observer using a checklist. The anonymous observers are unit educators and

charge nurses. All the patient beds on the Medical-Surgical Unit are private, so patient

information was not overheard by other patient's or other patient's family members. The

checklist contained the following:

1. Both nurses were at the patient's bedside for all, some, or none of the report

2. If the report was at the bedside, ask the patient if the nurses allowed them to provide
   input into the report.

3. If the report was not at the bedside, where did the nurses give a report?

4. If the report was not at the bedside, ask the nurses "why not?"

5. If the report was not at the bedside, ask the patient if the nurses allowed them to provide
   input into the report.

Following the initial data, an educational workshop was conducted at the monthly staff

meetings. One month after the education workshop was completed the same checklist was used

to evaluate the reimplementation of BSR. This checklist evaluation identified if the barriers

addressed in the workshops was adequate. If barriers are still present, or if new barriers are

identified, and additional education workshop will be completed.

Significance/Implications for Nursing

Growing concerns and frustrations among all the staff nurses and nurse managers

prompted the need to re-evaluate the current method of nurse shift report in an attempt to find an

alternate option to decrease the number of inaccurate shift reports, shorten the length of time of

report; while not compromising the completeness of report, and decrease the transmission of

erroneous and irrelevant patient information, with the goal of improving overall patient outcomes

and patient satisfaction. The importance of this issue and the need for constant improvement was

further supported by the JCAHO National Patient Safety Goals 2014 which calls for the

implementation and improvement of effective communication between caregivers (JCAHO,

2014).   According to Olson and Eoyang (2001), the most powerful processes of change are

made on micro-level involving interactions and relationships within small units. Strategic

and "macro-level" changes have the potential to occur best if the "small parts of the unit" are

receptive to change. Attendance at the monthly committee meetings, weekly discussions with

the chairperson of the committee, and ongoing discussions with the Director of Performance

Improvement proved to be a successful strategy for updating the committee on the progress of

the project, disseminating the initial evidence in support for the project, and working in

collaboration with the committee.

"Using current research in clinical care is an essential skill for healthcare professionals.

Organizations are challenged by how to increase EBP to meet quality outcomes goals" (Wilson

et al., 2015, p. 21). Organizations should associate with Magnet standards for strengthened

professional development strategies to achieve high-quality, evidence-based care (Wilson et al.,

2015). Nurses from hospitals with Magnet designation stated limited barriers to EBP and Magnet

hospitals had the utmost desire for EBP. Similar findings by Melnyk et al. (2012) regarding

barriers, suggested that Magnet facilities have a culture accommodating of EBP.

The re-implementation facility is currently actively pursuing Magnet Designation. A component the Magnet Committee is working on is found in Appendix E. The reimplementation of BSR encompasses the following Magnet Components:

1. Magnet Component I: Transformational Leadership: Sustain a culture of safety and quality in the delivery of patient- and family-centered care based on evidence from research and practice (Swanson & Tidwell, 2011). This Magnet Component will be completed through the re-implementation of BSR.

2. Magnet Component III: Exemplary Professional Practice. One characteristic of exemplary professional practice is scrupulous attention to communication processes (Swanson & Tidwell, 2011). Educators and Clinical Nurse Specialists will provide staff education at the unit level as the re-implementation of BSR are initiated system-wide for the inpatient units. With BSR factual communication among clinicians, whether it is nurse-to-nurse, doctor-to-doctor, or nurse-to-doctor communication. It is used to confirm that patient information is consistently and accurately communicated, especially during critical events, shift handoffs, and patient transfers between levels of care.

3. Magnet Component IV: New Knowledge, Innovation, and Improvements. With the re-implementation of BSR, the use of resources and evidence-based practices is based on research identified in the literature review (Swanson & Tidwell, 2011).

Change-of-shift report takes place several times a day, yet there is a problem associated with the lack of communication and consistency that is essential for patient information to relayed in a timely manner. The goal of this project is to re-implement the current practice policy regarding BSR, that has not been enforced at the practice site. This re-implementation will improve communication for patient safety, and the quality of nurse care, which are components

of the Magnet Designation. "Nurses may be unaware of the inherent risks involved with shift

report and best practices in the literature to lessen those risks" (Clark & Persaud, 2011, p. 15).

Analysis of Results, Discussion and Significance, Limitations, and Dissemination

Analysis of Results

The intention of this DNP project was to develop a project improvement program with implementation and evaluation for bedside reporting at shift change. This DNP project was to improve nurse-patient communication and improve the overall quality of care. The outcome was a bedside shift report protocol and policy to be reimplemented by the administration at the site based on the findings of this DNP policy.

Setting

The setting for this project is a Medical-Surgical unit at a local hospital seeking Magnet Distinction, in the Midwestern portion of the United States. This project involves re-implementing the bedside report policy that has not been enforced since 2015.

Participant Selection

The participants for this project are nurses from a Medical-Surgical Unit. Participation in completing the surveys was voluntary. Of the 47 staff nurses on the unit, 35 nurses completed both surveys. Participants are nurses who will be members of this reimplementation project in the Summer and Fall of 2017. Registry nurses and student nurses were excluded from the project.

Instruments

Two instruments were used to collect data in this project. The first instrument was used to collect data through an anonymous survey that was handed out at a staff meeting when the preliminary information of the project was shared with the staff nurses. The survey identified data on demographics, feelings about family-and patient-centered care, staff input regarding

communication, and a checklist of the most important components of a handoff report (Appendix

C). The second instrument was a questionnaire to identified how handoff report was given and

received on the day of the staff meeting, where the project was initially introduced to the staff

nurses (Appendix D).

<center>**Survey Variables and Assumptions**</center>

The demographic variables that were assessed at the completion of the survey included

the number of years' experience in nursing, education level, and years at the practice site. Each

survey packet was labeled with page numbers on each page in the event the packet was

separated. Once the participants completed the surveys, they were placed in an envelope and into

a locked box in the manager's office. The project leader is the only person with a key to the

locked box. Envelopes were left in the manager's office to be sealed by the participant and then

placed by them into the locked box through the top slot in the box. The forms were picked up

daily by the project leader to maintain confidentiality.

It is assumed that the voluntary participants completed the surveys with all questions

answered prior to submitting the survey. It is also assumed that the volunteers were honest in

their answers and comments.

<center>**Analysis of Data**</center>

Section A provides demographic information on the nurses who participated in this

project. All survey data was transferred for analysis into the Statistical Package for the Social

Sciences (SPSS). Three participants (7.3 %) had 0-3 years of experience; eight participants (19.5

%%) had 2-3 years of experience; eighteen participants (43.9 %); eight participants (19.5 %) had

6-10 years of experience; and four participants (9.8 %) had more than 10 years of experience

(see Table 1). The majority of the participants have a Bachelor's Degree (BSN) at 97.6 %, and

one participant has earned a Master's Degree (MSN) at 2.4 % of participants (see Table 2).

TABLE 1: Statistics Regarding Nursing Experience of Participants ($N = 41$)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0-1 year	3	7.3	7.3	7.3
	2-3 years	8	19.5	19.5	26.8
	4-5 years	18	43.9	43.9	70.7
	6-10 years	8	19.5	19.5	90.2
	>10 years	4	9.8	9.8	100.0
	Total	41	100.0	100.0	

TABLE 2: Nursing Degree ($N = 41$)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	MSN	1	2.4	2.4	2.4
	BSN	40	97.6	97.6	100.0
	Total	41	100.0	100.0	

Note. BSN = Bachelor's Degree in Nursing; MSN = Master's Degree in Nursing.

Descriptive statistics are measures of central tendency including means, frequencies,

standard deviations, and ranges. Section B specifies information on the patient and nurse

working relationship. Two different statistical analyses were conducted on the questions from

Part B. A yes = 1 and no = 2 response for questions five and six confirmed that BSR was not

conducted by the participants ($N = 41$, standard deviation (SD) 4.826, and mean of 4.24), and

confirmed that BSR was not received by the participants (N = 41, SD .582 and mean of 4.24) on

the day they submitted the survey. The data sample responses from part B question 7, of the

survey, are characterized by the items on the survey (see Table 3). This data is referencing

nurse's perceptions of patient-family centered care for each patient each nurse cared for in a

given shift. Nurses on this unit care for four to seven patients depending on the shift. The means

ranged from 2.00 to 3.50 on a 5-point Likert-type scale, ranging from 1 = *not at all* to 5 = *extremely satisfied.* The responses to the remaining questions in Part B were not remarkable.

The data of the continuous variable know as skewness and kurtosis were used to analyze the data. The skewness value provides an indication of the symmetry of the distribution. For this portion of the data, the negative skewness indicates values clustering at the high-end of the scores (.276 to .000). This negative skewness (-.107 to -1.638) occurred with the nurse's responses of patient 1, 3, 4, and 6. This data illustrates the responses to the question were primarily between poor and good for patient/family relationship with the nurse. The higher the number of patients the lower the scores becomes, therefore, unsatisfied relationships.

Kurtosis, on the other hand, provides information about the "peakedness" of the distribution. Kurtosis values below 0 indicate a distribution that is relatively flat. This is reflected in the overall response distribution, as the majority of the nurse's responses for question 2 were between fair and excellent, with nearly even numbers in the middle of good and very good.

TABLE 3: Relationship with patient and family

	N	Minimum	Maximum	Mean	Std. Deviation	Skewness		Kurtosis	
	Stat-istic	Statistic	Statistic	Stat-istic	Stat-istic	Stat-istic	Std. Error	Stat-istic	Std. Error
Patient 1	41	1	4	3.34	.656	-1.049	.369	2.528	.724
Patient 2	41	2	5	3.37	.698	.276	.369	.101	.724
Patient 3	41	1	5	3.12	.640	-.107	.369	3.690	.724
Patient 4	41	1	4	3.10	.786	-.866	.369	1.137	.724
Patient 5	30	3	4	3.50	.509	.000	.427	-2.148	.833
Patient 6	12	1	3	2.58	.793	-1.638	.637	1.130	1.232
Patient 7	6	1	3	2.00	.632	.000	.845	2.500	1.741

For Part C of the survey, the most critical elements of a handoff report were identified (see Table 4). With the data received, the top ten critical elements of a handoff report were room

number, age, diagnosis, lab results, medications, IV/lines, system review, pain, activity, and vital

signs with scores ranging between 40 to 41. The second-most important data was followed by

social issues/culture, feelings, wounds, consults, and dressings with scores ranging between 36

and 39. According to the survey, the staff nurses are not very concerned about the patient's

weight, bedside environmental checks, and history, with total scores ranging between 0 and 6.

TABLE 4: Critical Elements of a Handoff Report

	N Valid	Missing	Mean	Median	Std. Dev	Min	Max	Total
Name	41	0	1.61	2.00	.494	1	2	15
Room Number	41	0	1.05	1.00	.218	1	2	40
Age	41	0	1.00	1.00	.000	1	1	41
Diagnosis	41	0	1.00	1.00	.000	1	1	41
Social Issues/Culture	41	0	1.07	1.00	.264	1	2	38
Lab Results	41	0	1.02	1.00	.156	1	2	40
Medications	41	0	1.00	1.00	.000	1	1	41
IV/Lines	41	0	1.00	1.00	.000	1	1	41
Feedings	41	0	1.12	1.00	.331	1	2	36
Isolation Status	41	0	1.39	1.00	.494	1	2	25
System Review	41	0	1.00	1.00	.000	1	1	41
Pain	41	0	1.00	1.00	.000	1	1	41
Activity	41	0	1.00	1.00	.000	1	1	41
Skin	41	0	1.46	1.00	.505	1	2	22
Wounds	41	0	1.05	1.00	.218	1	2	39
Consults	41	0	1.10	1.00	.300	1	2	37
Allergies	41	0	1.49	1.00	.506	1	2	20
Weight	41	0	1.93	2.00	.264	1	2	3
Bedside Environmental Checks	41	0	2.00	2.00	.000	2	2	0
History	41	0	1.85	2.00	.358	1	2	6
Teaching	41	0	1.71	2.00	.461	1	2	11
Dressings	41	0	1.05	1.00	.218	1	2	39
Vital Signs	41	0	1.02	1.00	.156	1	2	40

Comments and Feedback

In part B question 4 and 7 the participants were invited to add comments. Many of the participants offered opinions to their perception of barriers to bedside handoff report when the family is involved. The following are the top three comments: (a) 42% more time is spent in the report; (b) 31% family concerns; and (c) 12% HIPAA concerns, that the privacy and confidentiality would be compromised.

Initial Observation

The anonymous observers watched shift handoff report for each shift for five days. A descriptive analysis was completed on the initial observation. Of the 49 staff nurse reports observed, eight shift handoffs were not completed at the bedside (Table 5). A yes = 1 and no = 2 response for question 1 confirmed that BSR was conducted by the participants ($N = 49$, standard deviation (SD) .37344, and mean of 1.1633).

Table 5: Initial Observer Survey

	N	Minimum	Maximum	Mean	Std. Deviation	Skewness		Kurtosis	
							Std.		Std.
	Statistic	Statistic	Statistic	Statistic	Statistic	Statistic	Error	Statistic	Error
INTOBS	49	1.00	2.00	1.1633	.37344	1.880	.340	1.599	.668
Valid N (listwise)	49								

Comments and Feedback

While a majority of the staff nurses participated in BSR, eight nurses did not embrace and followed the reimplemented policy even with an educational in-service. The comments that the observes received for question 2 (if the report was not at the bedside, where did it take place?), the report was given at the main nurse's station, outside of the patient's room, but not in the

room, and in the break room. The responses to question 3 (if the report was not at the bedside,

why not?):

- Did not want to wake the patient

- Did not want to take about the patient's condition in front of the patient

- Did not want to talk to the patient in front of family members or visitors

- Thought report at the bedside would take longer to give and receive if the patient asked
  questions

- Doesn't agree with the policy and has always given a report at the nurse's station, and
  information was given in a timely manner.

- Confidential information could not be shared in front of the patient and family.

Additional education will need to be given to the eight nurses that did not follow the

reimplemented policy.

Discussion of the Findings

Inefficient patient handoff reports are regularly established in the literature as a patient

safety problem despite the method of the shift handoff used (Birmingham, Buffum, Blegen, &

Lyndon, 2015; Leger & Phillips, 2017). Some subjects from the surveys were comparable to

those ascertained in the literature. The most frequent theme cited expressed fear and

apprehension as to what could and could not be discussed at the bedside. Some were concerned

with mentioning matters that may not have been discussed with the physician or nurse

practitioner, like new diagnoses and test results (Anderson & Mangino, 2006; Birmingham et al.,

2015; Cairns et al., 2013; Evans et al., 2012; Radtke, 2013; Sand-Jecklin & Sherman, 2013).

While the participants did not come out and say Health Insurance Portability and Accountability

Act (HIPAA) violations, they eluded to sensitive issues being discussed at the bedside.

Literature supports a decrease in the length of the overall time it took to give and receive a shift handoff report at the bedside versus traditional methods of shift handoff (Anderson & Mangino, 2006; Birmingham et al., 2015; Cairns et al., 2013; Caruso, 2007; Tidwell, 2011). Participants expressed concerns regarding the length of shift handoff and that longer reports will lead to late starts with patient care and feel they are behind from the start of the shift,

The final subject stated additional sentiment. The participants expressed frustration when having to discuss waking the patients for the shift handoff, especially for the morning shift. Patients are frequently awakened for vital signs, EKGs, Labs, between the hours of 0400 and 0700. Participants mentioned that patients complain about in the morning are the hourly sleep disturbances. With the sleep deprivation that the patients are experiencing in the hospital, participants are concerned with these patients not understanding what is being discussed at the bedside and becoming agitated at the staff. The literature was searched studies on sleep deprivation and understanding, but there were no findings found to support this, there is no evidence to support this.

Significance

Bedside handoff report requires clear guidelines for policies and practices that communicate standards by the organization (Clarke & Persuade, 2011; Tan, 2015; (Whitty, Spinks, Bucknall, Tobiano, & Chaboyer, 2017). Currently, the study site has been working on obtaining Magnet Accreditation and re-working their policies that have not been followed. The policy reimplementation requires Situation, Background, Assessment, and Recommendation (SBAR) as a written and verbal communication tool. The SBAR has specific guidelines to facilitate communication at shift change. An organizational policy will provide clear expectations of what information is acceptable to communicate away from the bedside, and how

the information is to be delivered by the nurses at the bedside. Within the policy, the when and

how of shift handoff is conducted, and the surveillance of the staff nurses is addressed. The unit

manager, educator, and charge nurses are tasked with the job of ensuring compliance with the

policy and the reimplementation process.

The literature reviewed supports the use of BSR; however, nursing leadership must

continue to be aware of the participant's concerns and the development of the plan to address the

concerns. Vigilant surveillance is needed to ensure the policy is enforced. Leadership needs to

speak to irregularities and the identified barriers to the policy practice change and

reimplementation to remove the perceived barriers (Sand-Jecklin & Sherman, 2013).

The nursing staff will require education yearly on the practice policy change to remain

compliant with the new policy. Nurses must clearly and openly understand all expectations to

which they will be held accountable.

Implications

While shift changes take place multiple times a day, there persist to be concerns related to

the lack of communication consistent with essential patient information in shift handoff report in

a timely manner. The goal of this project was to create a plan to empower and educate the

nursing staff to improve bedside shift report, to improve the communication skills to promote

patient safety and quality in nursing care using the information identified in the participant

surveys.

Staff nurses were not aware of the evidence-based and best practices in the literature

related to BSR to lessen the safety and quality risks to patients (Tan, 2015). Leadership is

essential in promoting the literature findings in BSR. The leadership understands and can

enhance the policies and practices that support the organizational goals. With the organizational

and policy goals patient safety and patient- and family-centered care can be achieved (Whitty et al., 2017).

Barriers and inconsistencies in shift report are important to discuss. Effective communication skills are paramount to reduce the barriers to confidentiality and sensitive issues (Cairnes et al., 2013). "Nearly two-thirds of sentinel events in acute care centers can be attributed to miscommunication of patient information at shift change" (Cornell, Gervis, Yates, & Vardaman, 2013, p. 426). Nurses must understand the critical need and the positive impact of timely, consistent, and effective shift reports are to providing safe, quality patient care.

Limitations

Several limitations were uncovered in this project. The nurses who participated in this project were from one unit in a solitary facility, thus, restraining the generalization of the results. The nurses offered their thoughts about what they felt were barriers to bedside reporting. The thoughts and attitudes, of the nurses, could be influenced by what was being discussed with fellow staff members. The nurse's responses may have been biased by what they thought they heard. Many of the facilities nurses float from floor to floor according to the census and may be experiencing the same barriers to BSR. Survey's on the additional unit would need to be analyzed.

All nurses received an educational in-service prior to the implementation of BSR, in educational in-services. Conversely, the nurses stressed the need for further education on the purpose and rationale of BSR. Furthermore, the nurses acknowledged the lack of education for the patient and family members concerning BSR. It is recommended to include project team to assist in determining the impact of a committed report time on admissions and transfers.

"Scholarship is not only the production of new knowledge but includes sharing that knowledge through scientific and social exchange" (Zaccagnini & White, 2011, p 64). Distributing results is an imperative characteristic of scholarship. Hence, results of the survey results were shared with the project and leadership team. As a result, the Chief Nursing Officer (CNO) bade to have the findings of this project presented to the Magnet Committee.

<div align="center">**Dissemination**</div>

Based on the recommendation made by the DNP student to the magnet committee and hospital leadership team, the facility can presume to see an improvement in shift report with enriched nursing communication. A pretest and a posttest method of evaluation can support the facility with an evaluation of understanding achieved during the nursing in-services. In order to ensure the effectiveness of the BSR policy change, the facility will establish a competency validation as part of the facility orientation.

Nursing Orientation

The survey outcomes signified a deficiency of staff education related to shift report. The facility has developed a BSR policy and is incorporating the policy into nursing orientation. The orientation education will be conducted in the classroom using PowerPoints developed for this project (Appendix K and L), web-based training, and then on the facility unit. Communicating of shift handoff information in orientation provides the opportunity for the facility to accentuate expectations from the start. The facilities orientation "is to assure that all employees are competent to perform the duties and responsibilities of their job as outlines in the job description and are consistent with policies and practices relating to patient safety" (Competency Assessment Program, 2013, p. 1).

A presentation was developed and disseminated to the magnet committee (Appendix K). The magnet committee will examine how the project can be supervised long term.

Conclusion

Inaccuracies in communication at the change-of-shift report are answerable for two-thirds of sentinel evens in hospital today (Cornell, Townsend-Gervis, Yates, & Vardaman, 2013). While the literature defines barriers to BSR, it was not acknowledged if medical-surgical nurses recognized those similar barriers that keep them from presenting the change-of-shift report at the patient's bedside at this organization. Survey's and observations were used to comprehend the barriers from the medical-surgical nurses' viewpoint in order to customize education to this facility based on findings and evidence among the nurses themselves.

A facility policy improvement was needed and fashioned to describe the significance and goals of BSR and define the particular expectations of the nursing staff. An educational strategy was established to aid the nurses in achieving the essential abilities to report at the bedside for uniformity among all the nursing staff and to meet the terms of regulatory requirements.

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Appendix A

Studies Using CEX				
Participants	**Intervention**	**Outcome Measures**	**Results**	**Conclusions**
25 nurses	Integration of simulated-based handover into teamwork and communication seminar.	Development in preconfigured quality checklist scores of observed handovers.	Statically noteworthy increase in handover compliance after the intervention.	Simulation-based training can improve handover and patient safety (Berkenstadt et al., 2008).
72 Interns	Senior interns instructed sessions on handover and provided feedback.	The analysis is measuring observations of attitudes, knowledge, and ability to transfer patient care and feedback of value of handover process.	The statistically notable increase in awareness of the ability to hand over patients.	The structured handover program enhanced the contributing interns' insights of their knowledge of the handover process and their competence to transfer care effectively (Chu et al., 2009).
65 nurses and medical officers	Aggressive communication skills class as part of overall handover improvement project.	Enhanced opinions and confidence of staff on a questionnaire post-implementation.	80% of staff stated they were more certain at handover post-implementation and 68% said handover had improved.	The evidence supports the use of specific communication training as it improves nursing confidence in handover (Clark, Squire, Heyme, Mickle, & Petrie, 2009).
32 medical students	90-minute class on handover. One week later, a 2-hour standardized	Pre- and post-class surveys by students assessing their preparedness	Assessment of pre- and post-workshop survey data revealed a statistically	The standardized handover training class improved

	handover course with the creation of handover CEX tool for assessment.	for handover. Approval of the faculty and staff with the assessment instrument, the handover CEX.	significant improvement in preparedness for performing effective handover.	students' self-confidence and was rated approvingly by trained observers. (Faran et al., 2010)
15 doctors (residents)	30-minute class followed by a 30-minute small-group practice session with evaluation.	Pre- and post-training examination of handover.	Statistically important progress in all outcomes.	The class helped the doctors develop skills, including competencies in learning, communication, and practice-based. (Gakhar & Spencer, 2010).
32 participants	Course design followed by a small and large group interactive discussion and then small-group sessions with practice and feedback.	Pre- and post-assessments of comfort in receiving and giving handover.	Perceived comfort at providing sign-out increased.	The curriculum was well-received by contributors. (Horwitz, Moin, & Green, 2007).
69 medical students	Simulated handover practice in small groups, with accompanying website materials.	Evaluation of students' thoughts of involvement and score on 10-item handover checklist.	Mean score of 81.5% on the checklist with constructive comments on intervention.	The simulated inpatient unit was an efficient and effective environment to teach the students about handovers in a demanding and busy inpatient unit setting (Klamen, 2009).
Doctors on neurology (total not specified)	Educational meeting is representing a literature review, local review and	Handovers assessed pre- and post-intervention.	Significant changes in data at baseline versus post-intervention.	Early training is essential for clinical handover (Lyons,

	professionals' views.			Standley, & Gupta, 2010).
17 doctors in gastroenterology residency	Lectures on handover to communicate background information about handovers.	Self-assessment rating of the site and of personal handover.	Improvement in median self-handover scores.	No clear conclusions. (Malter & Weinshel, 2010).
14 nurse specialists	2-hour course on handover.	Intervention assessed by contributors on learning outcomes achieved and apparent value.	All contributors thought the session was valuable.	No clear conclusions made. (Nestel, Kneebone, & Barnet, 2005).

Appendix B

Email from Unit Manager regarding approval for re-implementation of BSR

( ) DNP Project I

Inbox x
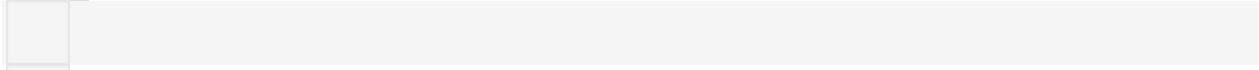
Stacey DeLeon **<dnp17c.stacey.deleon@nv.touro.edu>**   MAR
                                                                            08

to ▮▮▮▮▮▮▮▮▮▮▮▮▮

▮▮▮▮▮▮▮

Following up on our meeting and discussion regarding BSR and the Magnet process, I understand that I have your permission to use your Medical/Surgical Unit for the re-implementation of BSR following the recommendations of the Magnet Committee.

Thank you,

Stacey De Leon MSNEd, RN
Touro University of Nevada DNP Student

▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮   MAR
                                                                            09

to me

Stacey,

Yes, I am excited to be a test site for the re-implementation of Bedside report. I want any information about the process shared with me, and all of my staff will be involved in this process.

Appendix C

Handoff Survey

Section A: General Demographics – Nursing
Please answer the following questions by marking the appropriate box:

1. Years of experience as an RN:
   [ ] 0-1 year
   [ ] 2-3 years
   [ ] 4-5 years
   [ ] 6-10 years
   [ ] more than 10 years

2. Your nursing degree:
   [ ] ASN
   [ ] BSN
   [ ] MSN
   [ ] other

3. Are you currently in school?
   [ ] yes
   [ ] no

4. How long have you worked at Richard L Roudebush VAMC?
   [ ] 0-1 year
   [ ] 2-3 years
   [ ] 4-5 years
   [ ] 6-10 years
   [ ] more than 10 years

5. Did you precept at Richard L. Roudebush VAMC?
   [ ] yes
   [ ] no

Section B – Patient-Family Centered Care Questionnaire

1. Did you give handoff report at the bedside today?
   [ ] yes
   [ ] no

2. Did you receive handoff report at the bedside today?
   [ ] yes
   [ ] no

3. If yes, was the family/patient involved in the report?
   [ ] yes
   [ ] no

4. What are some hindrances to including the family in bedside handoff report?
   _____
   _____
   _____
   _____
   _____

5. How satisfied are you with the report you **received** today?

1	2	3	4	5
Not at all		Satisfied		Extremely Satisfied

6. How satisfied are you report you **gave** today?

1	2	3	4	5
Not at all		Satisfied		Extremely Satisfied

7. How would you rate your relationship with the patient and family today? Please answer once for each patient you cared for.

   Patient #1

1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent

   Patient #2

1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent

   Patient #3

1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent

Patient #4

1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent

Patient #5

1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent

Patient #6

1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent

Patient #7

1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent

8. Do you think your relationship with the patient/family impacts your job satisfaction?

1	2	3	4	5
Not at all		Satisfied		Extremely Satisfied

9. Do you think patient satisfaction is related to the relationship a patient/family develops with the nurse?

1	2	3	4	5
Not at all		Satisfied		Extremely Satisfied

Additional comments:

_____
_____
_____
_____
_____

Section C: 10 Most Critical Elements of a Handoff Report

Please indicate which of the following items would be **the top 10 elements required for all shift handoff reports:**

		Yes	No
1	Name		
2	Room Number		
3	Age		
4	Diagnosis		
5	Social Issues/Culture		
6	Lab Results		
7	Medications		
8	IV/Lines		
9	Feedings		
10	Isolation Status		
11	System review (related to diagnosis): • Respiratory Status • GI • Neuro		
12	Pain		
13	Activity		
14	Skin		
15	Wounds		
16	MD consults		
17	Allergies		
18	Weight		
19	Bedside environmental checks		
20	History		
21	Teaching		
22	Dressings		
23	Vital Signs		

24	Other (specify)		

Thank you very much for your voluntary, anonymous participation! Please return to the locked box in the manager's office 😊

Stacey De Leon MSNEd, RN (DNP student)

Appendix D

Project Implementation Survey Form to collect information about our current hand-off report.
1. On average, how long does it take to give a report?
   a. Greater than 30 minutes
   b. 30 minutes
   c. 20 minutes
   d. 15 minutes
2. When receiving the report, is it presented in an organized format?
   a. Never
   b. Sometimes
   c. Most of the time
   d. Always
3. All of the information received during report is accurate?
   a. Never
   b. Sometimes
   c. Most of the time
   d. Always
4. When giving a report, is it presented in an organized format?
   a. Never
   b. Sometimes
   c. Most of the time
   d. Always
5. Is report given at the bedside?
   a. Never
   b. Sometimes
   c. Most of the time
   d. Always
6. For patients to be able to participate, are they involved in bedside report?
   a. Never
   b. Sometimes
   c. Most of the time
   d. Always
7. How often is an accurate plan of care reported during a change of shift?
   a. Never
   b. Sometimes
   c. Most of the time
   d. Always
8. What effect has using the electronic SBAR reporting tool had on patient safety?
   a. Never
   b. Sometimes
   c. Most of the time
   d. Always

Appendix E

Magnet Accreditation Outcomes

With the recent implementation of this process, the workgroup is still gathering data for the fiscal year 2016.

Metric	Baseline	Goal	Countermeasures *Fill in when needed in sustainment phase*
Length of report per patient	2-10 minutes	2-3 minutes	
Falls at change of shift	33-FY16	0	
Rapid Response after shift change	35-FY16	Reduce 50% by 1st Qtr FY17	
ePIR (Missed medications)	76	0	

Appendix F

Bedside Handoff Process:
1. Establish oncoming nurse familiarity with the patient and communicate patient demographic data.
2. Using the VAs approved format:
   a. Review significant patient profile data
   b. Review and update significant event/transfer summary
   c. Review the patient history and daily assessment
   d. Review current plan of care and evaluate progress towards goals
   e. Review needs and progress on education outcome record
   f. Review Physician's medical plan of care: note any changes or new orders and determine completion status
3. Go to the bedside:
   a. Introduce on-coming nurse to patient and family
   b. Confirm the plan of care with the patient and family
   c. Check patient ID bank, allergy bank, and IV site and fluids
   d. Do a quick safety check of the environment (Ambu bag, suction, extra trach, etc.)
   e. Assess priority body systems
   f. Assure the patient and family that you will attend to their needs as soon as the report is completed.

Appendix G

Standard Work – Bedside Reporting – On coming nurse (Inpatient)		
Last Updated: 5/30/2017	Owner:	Revision number: Revised by:

Purpose:

	Steps	Details	Diagram, Work Flow, or Picture (if applicable)
1	Arrive and be ready to work	Please be prompt and ready to receive report at the beginning of your shift, i.e., All belongings and lunch put away, side conversations completed, work supplies ready, etc	
2	Look at assignment	a. Receive assignment from charge nurse b. Review and know patient assignment	
3	Find off going nurse	Immediately find the off going nurse, they will not come looking for you.	
4	Transfer report sheet	Off-going nurse gives updated photo-copied hand-off tool (report sheet)	
5	TBA report (preliminary discussion) **MAX 30 SECONDS**	Prior to contact with patient, discuss sensitive information, i.e., • Not to include teaching moments • Unknown diagnoses • Unknown test results • Blood-borne issues (STIs) • Personal preferences of patient • High-risk flags **MAX 30 SECONDS**	
6	Find patient for bedside report on unit	If patiently is not present for bedside reporting a verbal report will be given inside the patient's room.	

		Safety check must still be completed. See box 9 Upon arrival of patient, assure patient identifiers are confirmed.	
7	Introductions/complete whiteboard	Off-going introduces the oncoming nurse with managing up vocabulary, i.e., *"This is Nurse Johnson, and she will take GREAT care of you today* ☺*"*. **Remember to update the whiteboard**	
8	Bedside reporting	This is an opportunity to engage the patient in his/her care during the hand-off process. Using the hand-off tool (report sheet) a. Identify patient by checking the armband and asking the patient their full name and SSN b. Assure hand-off tool matches patient identifies c. Identify patient allergies by checking armband d. Starting with demographics, both RNs discuss the information on the hand-off tool relevant to the patient (priority assessment)	
9	Safety check	Safety check includes: a. Identifiers b. Fall risk c. IV site d. Fluids and settings e. All drains and tubes f. Wounds g. Equipment settings h. ICU AMBU i. Suction Set-up j. Bed low & locked	

		k. Call light	
10	Q & A	Address questions/concerns by the patient by asking the patient, i.e., *"Is there anything I left out, or something you would like to get done for the day?"*	
11	Conclusion of report	Before leaving the patient, conclude by saying, i.e., *"It's been an honor to take care of you today. Someone will be back shortly."*	

Appendix H

Observers Checklist for Bedside Shift Report

Initial Assessment: Observe all three shifts for five days each shift.

4. Both nurses at the bedside   Yes   No

5. Not at the bedside, where did the nurses give report

    _____

6. Not at the bedside, ask the nurses "why not."

    _____

*The "why not" data will be used to develop educational workshops on barriers to bedside report

will be completed then the above data will be reevaluated.

The PDSA cycle model is one of continuous improvement and evaluation. This will be essential

to re-implement the BSR practice policy.

Appendix I

Observers Checklist for Bedside Shift Report

Final Assessment: Observe all three shifts for five days each shift.

7. Both nurses at the bedside   Yes   No

8. Not at the bedside, where did the nurses give report

_____

9. Not at the bedside, ask the nurses "why not."

_____

*The "why not" data will be used to develop educational workshops on barriers to bedside report will be completed then the above data will be reevaluated.

      3. One month later observe using the same checklist

      4. Re-evaluate to see if new barriers exist and re-educate staff.

The PDSA cycle model is one of continuous improvement and evaluation. This will be essential to re-implement the BSR practice policy.

Appendix J

I am looking for all 8th floor Medical-Surgical Registered Nurses to participate in an evidence-based practice project on shift handoff. I want to gather nurses' to participate in a survey and educational in-service on bedside shift report. After the education in-service you will be evaluated on your bedside shift report.

What do you need to do? Just participate in a 5-minute survey and one of three in-services. The in-service will be in the unit education conference room.

August 1st at 0700
August 2nd at 1500
August 3rd at 2300

Contact Stacey De Leon at 260-443-6693 or at dnp17c.stacey.deleon@nv.touro.edu for more information. This is an important handoff report change to the existing policy.

Appendix K

Reimplementation of Bedside Report

Stacey De Leon MSNEd, RN

Background

- Problems associated with change-of-shift report
  - Lack of consistency and structure
  - Potential failures in communication
  - No opportunity for patient to be involved in plan of care
- Ineffective communication contributes to:
  - Adverse and sentinel events
  - Errors
  - Care omissions
  - Delayed, inappropriate, or repeated treatments
  - Increased lengths of stay
  - Avoidable readmissions
  - Increased costs

(Cairns, Dudjak, Hoffmann & Lorenz, 2013; Halm, 2013; Jeffs et al., 2013; Riesenberg, Leitzsch, & Cunningham, 2010)

Background (Continued)

- Support of bedside shift report
  - Effective communication
  - Better health outcomes
  - Patient-focused care
  - Application of evidence-based practice
  - Patient involvement in handover process
  - Perform safety and quality checks
  - Ask questions and clarify information
  - Check for misinformation
  - Visualizing patient

(Jeffs et al., 2013; Radtke, 2013; Petersen, Blackmer, McNeal, & Hill, 2013)

Problem

- Organizational goal to move shift report to bedside
- Evidence supports bedside shift report
  - Patient safety
  - Quality outcomes
- Observations on a medical/surgical unit at change-of-shift revealed nurses were not consistently at the bedside
- Unknown what medical/surgical nurses perceive as barriers to moving shift report to the bedside

Project Significance

- Compliance with The Joint Commission
  - Ability to ask and answer questions
  - Informed patients and families
- Meet organization's goal of patient- and family-centered care
- Identification of barriers will:
  - Inform staff and leadership
  - Serve as a guide for change management strategies and education sessions
  - Inform other units

Purpose

- As floor nurses' hand on their patients to the next shift, there needs to be a standardized way to accomplish this. Literature does not support the audiotaped, written, or spoken face-to-face report at the nurse's station Anderson & Mangino, 2006; Benham-Hutchins & Effken, 2010; Reinbeck & Fitzsimons, 2013). The EBP approach to shift report is taking on a holistic ideal. Creating policy based on EBP for a bedside, rounds report may improve patient outcomes, can improve operational costs, decrease hospital stays, and reduce the chances of some preventable adverse events.

Theoretical Framework

Restraining Forces

Change in culture
Concerns about patient confidentiality
Sensitive issues/family issues
Perceived increase in length of report time

Driving Forces

Patient safety
Effectiveness and thoroughness of report
Nurse and patient satisfaction
Patient- and family centered care
Organizational goals

Desired Outcomes

CEX Tool

- CEX tool was used for staff education

Teaching Methods
- Small and large group sessions or classes
- Simulation experiences with debriefing
- Role-playing exercises with feedback
- Online materials (videos, text, and protocols)

Content Themes
- Management of Information
  - Structured Checklists
  - Mnemonic Devices
- Team-Work/Leadership/Communication
  - Confirmation that team members are on the "same page"
  - Service modeling handover
  - Understanding delivery and receiving of information
- Error Awareness and Professional Behavior
  - Grounded in actual errors in place of work
  - Implications of handover for patient safety

PDSA Cycle

The PDSA cycle model used to implement the project/plan

Plan – recognize an opportunity
Plan a change
Estimate the impact of the planned change
Do – test the change
Carry out a small-scale study
Study – review the test results and identify what you have learned
Act – take action based on what is learned in the study
If the change did not work, repeat the cycle with a different plan, if the change is successful, incorporate what is learned from the test into the work process used in the area

The PDSA cycle is repeated over and over to improve the process continuously

1. Plan
2. Do
3. Study
4. Act

Data Collection and Analysis

- Classic Analysis Strategy
  - Verify themes
  - Categorize results
    - Descriptive summary of each category
  - Verification of results with project group

Descriptions of Barriers in Performing Bedside Report

Themes
- Confidentiality and Sensitivity

- Not knowing what can and cannot be said at the bedside
- Afraid of bringing up something the physician has not told the patient and/or family
- Certain things that the nurse needs to know but shouldn't be said in front of the patient (i.e., psych consult, behaviors, diapers, etc.)

Descriptions of Barriers in Performing Bedside Report

- Incomplete or Ineffective Report

- Constant interruptions (breaks up flow of communication and may inadvertently omit important information):
  - Phone calls, call bells (everyone is getting report so there is no staff available to answer call bells)
  - Nurses/patients asking questions throughout report instead of listening first then asking
    - Patient needs: toileting, coffee, pain meds, etc.
- Lack of consistency in report resulting in too much or not enough information
- Rushing to give report to 1 or 2 other nurses
- Censoring information given at the bedside resulting in compromised transfer of information to nurse; not the same as if given in private

Descriptions of Barriers in Performing Bedside Report

- Lengthy Report

- Interruptions
  - Patients/nurses asking too many questions
- Waiting around to get report; often have 2-3 nurses to get report from, often not receiving report until 0800
- Results in being late with morning medications and treatments – could be 1000 or 1100 before all patients are see
- Attending to patient needs during report

Descriptions of Barriers in Performing Bedside Report

- Unprotected Time for Report

- Must take report on new admissions and transfers during report time
- Results in significant interruption and potential loss of information

- Patient Dissatisfaction

- Waking patient for morning bedside report
- Waking them frequently is the biggest complaint from patients
- Patients don't understand a lot of the information presented, especially confused patients

Recommendations

- Hospital policy providing specific expectations of bedside shift report
- Nurse-led work group to determine essential information to pre-populate computer-generated report sheet
- Consider the possibility of a dedicated report time from 7:00-7:30
- Stagger start times to free up staff to answer call lights and limit interruptions to those giving and receiving report

Conclusion

- Many barriers identified
- Some consistent with the literature and some new knowledge
- Developed a workshop that will address barriers

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Appendix L

Staff educational in-service PowerPoint for bedside report.
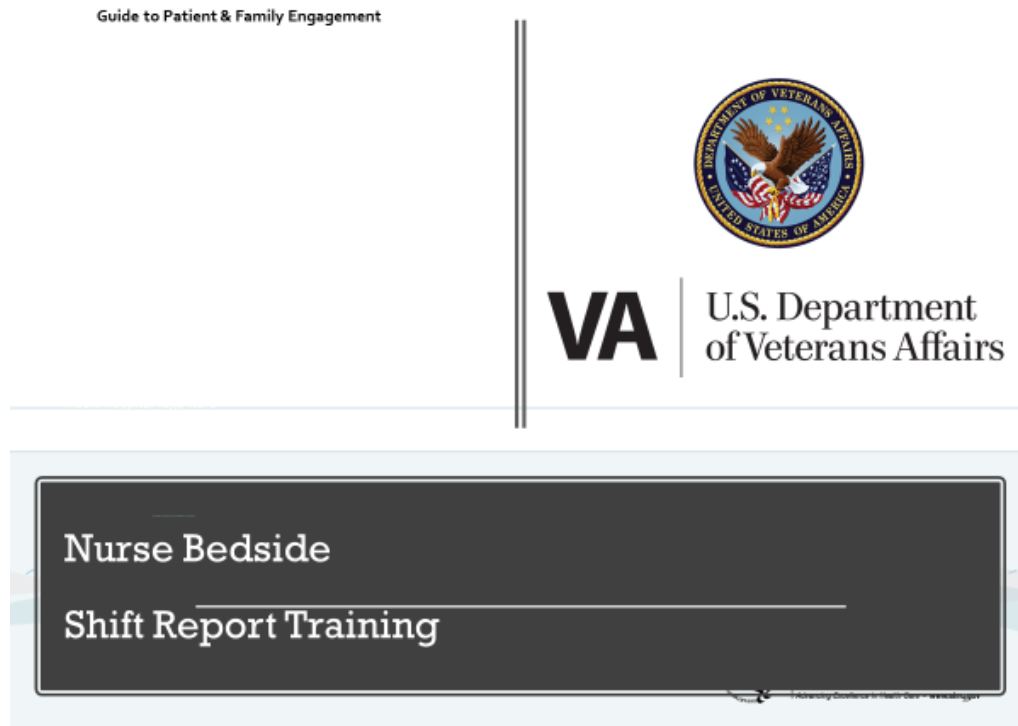
• As people enter the room:
– Ask them to sign in. It is helpful to have a sign-in sheet that asks for contact information to keep track of attendees.
– Introduce yourself, ask their name, and ask them to fill out and put on a name tag.
– Give each attendee a copy of the session handouts (see below).
• Open the session by welcoming people.
• Introduce yourself and co-presenters. Give your name, position or title, and role.
• If patient and family advisors are participating (see slide 10): Introduce patient and family advisors and thank them for participating in this session.
• Depending on the number of attendees, ask people to go around the room and very briefly (no more than 30 seconds) introduce themselves and share:
– Their name
– The biggest challenge they face when communicating with patients and families

We will begin today by talking about how engaging patients and family members helps us improve the quality and safety of care we provide.

Then we will talk about the components of bedside shift report – and the benefits of challenges of bedside shift report.

We will also discuss some issues around HIPAA and bedside shift report.

Then, we will be doing some practice exercises.

Questions are welcome at any time.

To set the stage for our conversation, I'd like to talk about the importance of patients and families as partners in ensuring and improving the quality and safety of care that we provide.
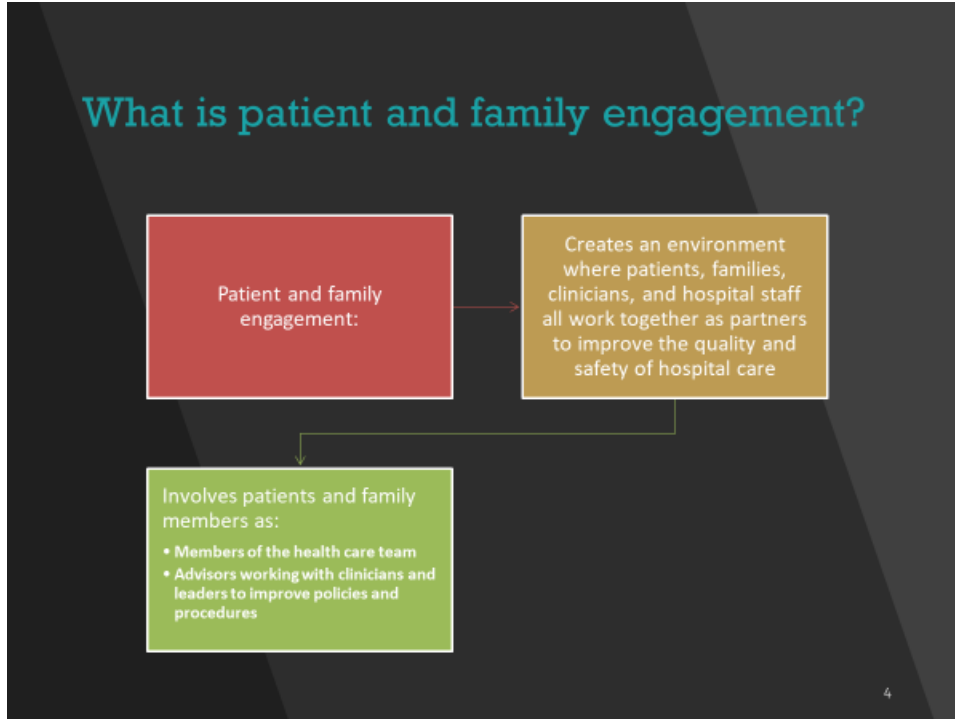
The ultimate goal of patient and family engagement is to create a set of conditions where patients, family members, clinicians, and hospital staff are all working together – as partners –to **improve the quality and safety of care.** This partnership is important because health care quality and safety have a direct effect on patients and families. It makes sense that we should ask patients and family members to take part in changes and improvements.

On one level, patient and family engagement means providing day-to-day care experiences that welcome and engage patients and family members as members of the healthcare team. For example, in our hospital, we provide opportunities for patients and family members to be involved in their care by:

- Making sure from the beginning that we invite patients and family members to partner with their healthcare team throughout their stay.
- Doing a change of shift report at the bedside, where patients and families can participate.
- Involving patients and families in discharge planning and plans for safe care at home.

On another level, patient and family engagement means that patients and family members are involved beyond their own care as organizational partners, or **advisors** – for example, working together with staff, clinicians, and leaders to improve policies, processes, programs, facility design, and education for hospital staff, clinicians and trainees in the health professions.

Patient and family engagement is NOT

- Getting patients and families to do what we want them to (it is a shared partnership where we listen to each other and decide on the best plan of action)
- Getting patients and families to like us (it is about improving quality and safety by communicating and partnering more effectively)
- Handing patients and families a brochure (a piece of paper alone will not get patients and families engaged)

- Abandoning our critical judgment (as clinicians, we work with the patient and family to help them choose what is right for them. We bring our clinical judgment to the table – it is important perspective as part of the healthcare team. But, not the only important perspective).

Patient and family engagement is an important part of providing patient- and family-centered care. According to the Institute for Patient- and Family-Centered Care, the core concepts of patient- and family-centered care are:

• Dignity and respect, which means listening to and honoring patient and family ideas and choices and using patient and family knowledge, values, beliefs and cultural backgrounds to improve care planning and delivery.

• Information sharing, which means communicating and sharing complete and unbiased information with patients and families in useful ways. Patients and families receive timely, complete and accurate details so they can take part in care and decision-making.

• Involvement, which means encouraging and supporting patients and families in care and decision-making at the level they choose.

• Collaboration, which means inviting patients and family members to work together with healthcare staff to develop and evaluate policies and programs.
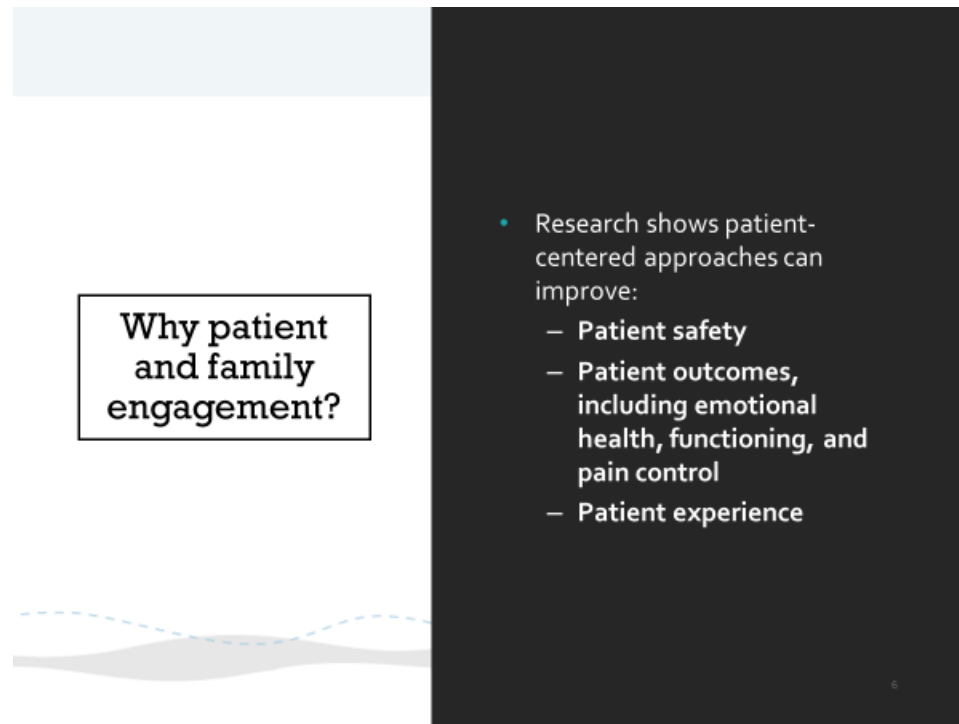
Various studies indicate that the effects of engaging patients and families translate into measurable improvements in quality and safety:

- **Improved patient safety**. Better communication, realized through patient and family engagement, has a direct impact on patient safety. For example, one study found that more than 70 percent of adverse events are caused by breakdowns in communication among caregivers and between caregivers and patients.[1] In addition, studies show that patients who are informed and engaged can help improve safety through "informed choices, safe medication use, infection control initiatives, observing care processes, reporting complications, and practicing self-management."[2] When patients and families are engaged in their care, an extra set of eyes and ears is available to help catch and prevent safety issues.

- **Improved patient outcomes**. Adopting patient-centered care strategies and engaging patients actively in their health care also has the potential to improve health outcomes. In a review of the literature, Debra Roter found that patient-centered care, realized through effective communication, had a positive effect on patient outcomes — specifically, emotional health, symptom resolution, functioning, pain control, and physiologic measures such as blood pressure and blood sugar levels.[3]

- **Improved scores on public reports of patient experiences of care**. The Centers for Medicare & Medicaid Services (CMS) publishes hospitals' patient experience scores on its public Web site (www.hospitalcompare.hhs.gov). The scores are based on a standardized survey known as the CAHPS® Hospital Survey. Many of the measures from the CAHPS Hospital Survey — particularly those related to patient-provider communication, pain management, and the provision of discharge information — reflect key elements of patient and family engagement. Hospitals that have implemented

strategies to improve patient engagement and the patient-centeredness of care have seen subsequent improvements in patients' ratings of care.[4]

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Why are we focusing on nurse bedside shift report?

- **Patient safety and quality.** Bedside shift report is an opportunity to make sure there is effective communication between patients and families and nursing staff. As noted above, one study found that more than 70 percent of adverse events are caused by breakdowns in communication among caregivers, and between caregivers and patients,.[1] Studies have shown that bedside shift report improves patient safety and service delivery.[2,3] For example, one study showed a decrease in patient falls during a change of shift, dropping from one to two patient falls per month to one patient fall in 6 months.[4]

  Improved communication during shift report can help catch potential medical errors in blood incompatibility, catheter-associated urinary tract infections, and air embolism, all of which are on CMS's list of hospital-acquired complications "never events."

- **Patient experience of care.** After implementing bedside shift report, hospitals reported an increase in patient satisfaction scores and improvements in the nurse-patient relationship.[5,6] Also, one study noted a sharp decline in the average number of call lights on by the end of shift change.[4]

- **Time management among and accountability between nurses**. After implementing bedside shift report, nurses have reported better able to prioritize their work or cases during their shift and an overall decrease in staff time.[4,6] One study noted a decrease in over-shift time by 100 hours in the first two pay periods on a 32-bed general surgical unit.[6] In another study on a 34-bed progressive care unit, a 2-month review of overtime data demonstrated an $8,000 reduction directly associated with the decrease in time for shift report.[4]

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Now we would like to talk a bit about what it is like to be a patient or family member at our hospital.

What is it like being a patient?

Clinicians and hospital staff	Patients and family
• Know how the hospital works and how to get things done	• Are strangers in this environment • Do not understand the system or culture • Know about their body and life situation better than hospital staff
• Know who hospital staff are and what they do	• Do not know who different staff are and what they do • May want family or friends to support them • May feel nursing staff are unavailable for multiple hours during shift change
• Are busy and under a lot of stress	• Are often in pain or uncomfortable, vulnerable, or afraid • Are worried and want to do what they can for the patient (family members) • Are aware that hospital staff are busy and may not want to bother you
• Want to provide high-quality and safe care	• Trust hospital staff to provide safe and quality care

9

Hospital staff and patients know about different things in the hospital and may not always be on the same page. One is not better than the other. There is no right or wrong, but it is important to acknowledge the differences as we move forward to work together as partners.

Nurse shift changes require the successful transfer of information between nurses going off duty and nurses coming on duty to prevent adverse events and medical errors. Patients and families can play a role to make sure these transitions in care are safe and effective.

We are going to talk about what bedside shift report is, the critical elements, the benefits, and some challenges.

REIMPLEMENTATION OF BEDSIDE REPORTING ON A
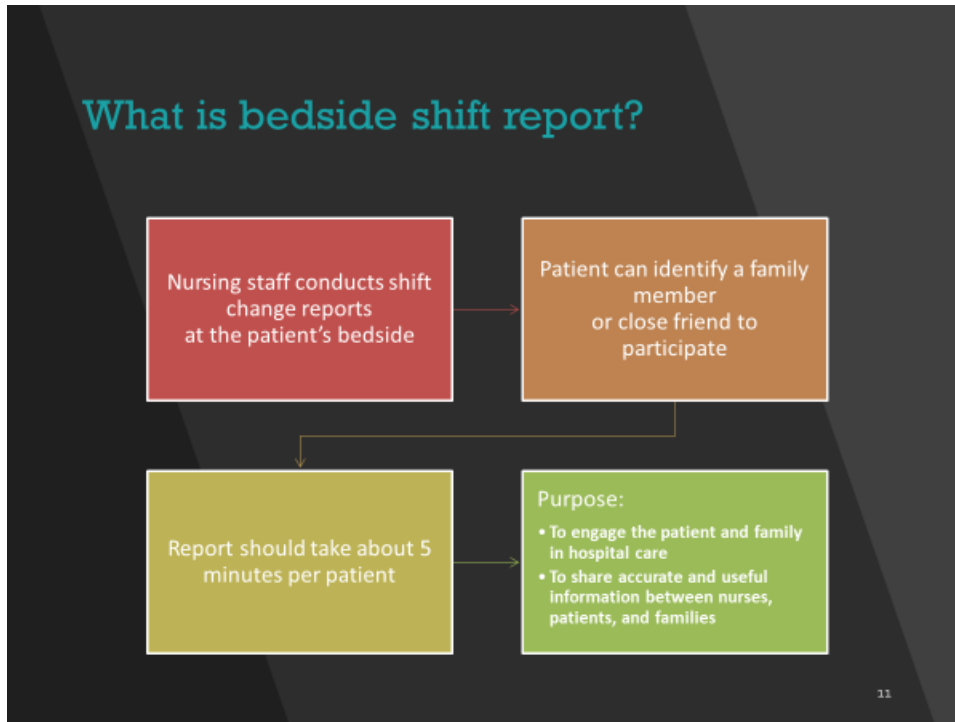
As indicated by its name, bedside shift report refers to conducting nursing shift changes at the patient's bedside. If patients choose, family members or friends can also participate.

The purpose of bedside shift report is to share information between nurses, patients, and families. It provides an opportunity for patients to actively engage in their care and for family members to participate. Although you may be worried that bedside shift report will take longer than regular shift report, hospitals that have implemented bedside shift report have found that this is not the case. Bedside shift report should take no more than 5 minutes per patient.

What are the Critical Elements of Bedside Shift Report?

On Admission:
- All patients/families must receive BSSR brochure and education on what to expect (These will be available from print-shop for inclusion in admission packets by May 1, 2014. In the interim, your Manager will share copies with you and direct you on where to get them for patient education)
- Ask patients/families if they want to be awakened to participate should they be sleeping
- Ask patients if they want family to participate in BSSR or if they want them to be asked to step outside of the room for privacy

Prior to end of Each Shift:
- Notify pt/family during last round that bedside report will occur soon
- Verify pt permission for family to be present during report (HIPAA)
- Check Pain Score/Adm. meds if needed

12

The Bedside Shift Report Checklist was adapted from Emory University's Bedside Shift Report Bundle. The checklist takes you through each of the steps, which are listed in the slide.

- You'll start by introducing the nursing staff to the patients and family members and inviting the patient and family to participate in the shift report.
- Open the medical record to the patient information or electronic workstation inpatient room.
- Conduct a verbal SBAR report with the patient and family. Use words that the patient and family can understand.
- Conduct a focused assessment of the patient (visually inspect all wounds, incisions, drains, IV sites and tubings, catheters, and so forth) and a safety assessment of the room (a visual sweep of the room for any physical safety concerns).
- Review the tasks that need to be done, such as labs or tests, medications administered, forms that need to be completed, and so forth.
- Identify the patient and family's needs or concerns.

Critical Elements of Bedside Shift Report continued...

For EVERY Change of Shift/Caregiver:

- Bedside Shift Report is required as part of handoff communication

- Bedside Shift Report must be done inside room (*exceptions: sharing of sensitive information such as psychosocial family dynamics, new diagnosis or lab results that the patient is not aware of yet. Your Manager/CNS/CNE will discuss unit specific examples with you during your unit specific training*)

- Bedside Shift Report should focus on sharing priority clinical and care information with collaborative, focused assessments of high-risk findings and equipment

- Bedside Shift Report should only take about 5 minutes per patient

13

Critical Elements of Bedside Shift Report continued...What information must be shared?

Minimum Information Required to be Shared During BSSR:

- Patient name, diagnosis and procedures since admission

- Changes in patient's condition or episodic events

- Current condition

- Current orders and goals reviewed, anything requiring follow-up

- IV site check, verification of fluids and rates

- Visual check and tracing of all lines, tubes, drains to patient

- Visual check of all dressings

- Equipment check

- Scan of environment for safety/hazards

14

Critical Elements of Bedside Shift Report continued... Setup for Success

Your Unit:
- off-going Charge RN makes patient assignments to support BSSR
- shift change huddles occur where off-going charge RN gives overview to all on-coming nurses before dismissing for BSSR
- use of standardized report form customized for your specific unit/patient population

Off-going RN :
- during rounds toward end of shift tell patient/family when BSSR (Bedside Shift Report) will take place
- remind patient/family that BSSR is to ensure a safe hand-off of care
- ask patient/family if they need anything prior to BSSR so focus can be on hand-off of information
- prepare for BSSR by having essential information/labs/etc. ready
- take WOW in room during BSSR to check meds and pertinent information with on-coming RN
- do a brief teach back with patient on a medication or other patient education you've covered during your shift

On-coming RN :
- carry report form for documenting information shared during report
- use whiteboard
- ask patient their goal for the shift
- ask patient if they have questions
- discuss plan of care for shift and anticipated discharge date
- inform patient/family when you will be back and what they can expect next

15

The Bedside Shift Report Checklist was adapted from Emory University's Bedside Shift Report Bundle. The checklist takes you through each of the steps, which are listed in the slide.

•   You'll start by introducing the nursing staff to the patients and family members and inviting the patient and family to participate in the shift report.

•   Open the medical record to the patient information or electronic workstation inpatient room.

•   Conduct a verbal SBAR report with the patient and family. Use words that the patient and family can understand.

•   Conduct a focused assessment of the patient (visually inspect all wounds, incisions, drains, IV sites and tubings, catheters, and so forth) and a safety assessment of the room (a visual sweep of the room for any physical safety concerns).

•   Review the tasks that need to be done, such as labs or tests, medications administered, forms that need to be completed, and so forth.

•   Identify the patient and family's needs or concerns

Hospitals that have implemented bedside shift report have observed a number of benefits. First, bedside shift report offers benefits for patients and families who report appreciating the opportunity to be involved in their care. Patients also report being more informed about their care, which helps decrease anxiety.

Conducting shift report at the bedside also demonstrates to patients and families that nurses are working successfully as a team to provide excellent care.

Quotes from an actual patient perspective in bedside shift report in McMurray A, Chaboyer W, Wallis M, et al. Patients' perspectives of bedside nursing handover. Collegian; 2011;18:19-26

Conducting shift report at the bedside also ensures that patients and family members are well-informed and better prepared for discharge. And, although we encourage patients and family members to be engaged in their care throughout their hospital stay, bedside shift report provides a specific opportunity for them to be involved and ask questions.
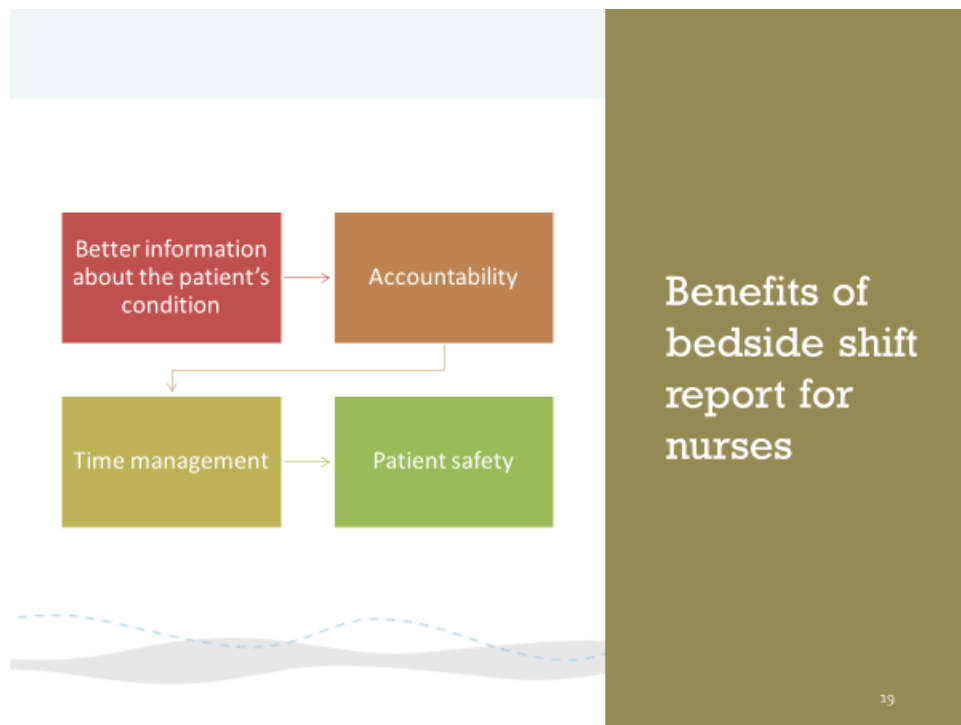
As noted earlier, there are many benefits of bedside shift report, including:

- **Information**: Nurses get more information about the patient's condition because they do a focused assessment of the patient in the room.
- **Accountability**: Makes the shift nurses who are going off duty more accountable before they leave. Nurses who are coming on duty should thank the nurses who are going off duty if they have done a good job during the previous shift.
- **Time management**: After participating in bedside shift report, nurses who are coming on duty have met every patient and family, know what needs to be done, and can prioritize care and complete work sooner.
- **Patient safety**: Potential mistakes are caught early in a shift change, and delays in tests or admission paperwork can be taken care of quickly.

Let's take a look at this video on bedside shift report, developed by Emory University.

After the video, lead the group discussion around each of the following questions:
- What are the overall impressions of the bedside shift report?
- What went well?
- What could have been done differently?
- What questions or concerns do you have about bedside shift report?

Specific points to discuss as needed:
- One of the nurses used the term "cardiomyopathy." Also, Vicki did not question the fact that her husband was listed as "1-A." Do you think most patients would know what these terms mean? What terms do you use that may be difficult for patients and family members to understand?
- How did the nurse respond to the patient's goal for the day? How did the nurses address the patient's concern about getting out of bed by himself? What could they have done differently to address the patient's concern?
- What types of things should not be discussed during bedside shift report in this case?

Invite patients and family members to participate at admission using bedside shift report brochure (Tool 1) Patient involvement may change over the course of their stay, so don't forget to ask each time. Some patients may be involved and engaged from the start. Others may want to be more involved as they get closer to discharge.

When you invite patients to participate at admission, they can arrange for their families to come at shift changes during odd hours (for example, 7 a.m.).Use the checklist to facilitate bedside shift report (Tool 2)

Don't discuss problems with the room or the situation with the outgoing nurse in front of the patient. Thank the nurse going off shift if everything is in good shape.
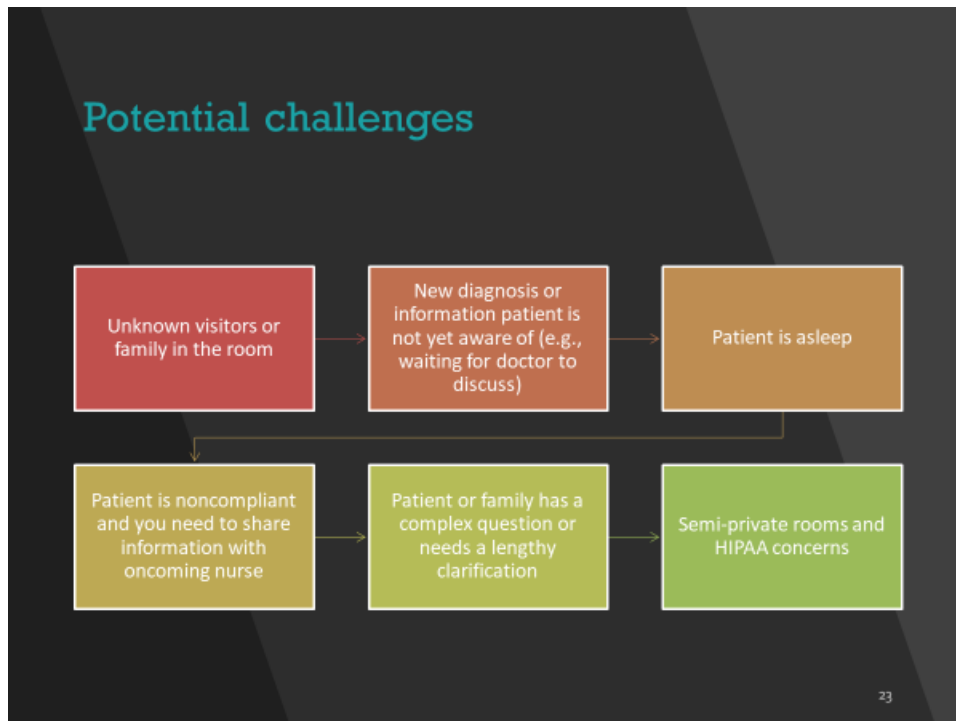
When there are unknown visitors or family in the room, explain what you'll be doing and ask the visitors to step out. If the patient wants them back in, say:

"We'll be talking about your condition and progress and examining your dressing. We want to maintain your privacy, but if you would like your visitors to be present, I can invite them back in."

If there is a new diagnosis that the patient is unaware of, give only the information that the patient is aware of in bedside shift report. Give any additional information to the nurse coming on shift after the bedside report or point to the item on your paper or report sheet such as "CT=brain tumor, patient unaware of dx." Do not report this in the hallway. Just point to it or cover it at the station.

If the patient is asleep, do you wake them for the report? In these cases, the nurse going off shift decides if the patient requires sleep. If the patient does need sleep, the nurse coming on shift observes the patient and equipment quietly and will give the patient the report later because he or she could not take part in it.

Sometimes, the patient may be anxious or "difficult." If the patient is noncompliant and you need to share information with the nurse coming on duty nurse. you can share this information with the patient and nurse coming on duty in the following way

"I have informed Mr. Jones that the doctor does not want him to smoke. Mr. Jones has chosen to go off the floor and smoke three times this shift."

If the patient or family has a complex question or needs a lengthy clarification, the nurse coming on duty should let the patient know that the question is important but that it will take longer than the time available during bedside shift report to answer it. Let the patient know that you will be back after shift report to fully answer the questions and address concerns.

Semi-private rooms / HIPAA concerns (next slide).

Critical Elements of Bedside Shift Report – SPECIAL SITUATIONS

- Sometimes there will be special situations where accommodations to Bedside Shift Report (BSSR) must be made

- Your Manager will define how these situations are to be handled on your unit

- BSSR must still occur but accommodations will be made

  - Unstable Suicidal/Homicidal/Violent patients

  - Patient Unresponsive and no family present

  - Patient Confused and Disoriented

  - Patient is non-compliant

  - Sensitive information that should not be included in BSSR

  - Family member always tries to take over BSSR and prevents you from having effective communication

  - Oncoming RN will be late

 - Code or other emergency is occurring on unit during shift change

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Critical Elements of Bedside Shift Report - What does Non-Compliance look like?

- Giving report at the nurse's station, in the break room, or away from the patient's room

- Talking about personal or unit issues when you're in the patient's room (*i.e. staffing is short today*)

- Using the excuse that the patient was "sleeping"

- Not educating patient/family on BSSR

- Not following BSSR expectations and outlined process
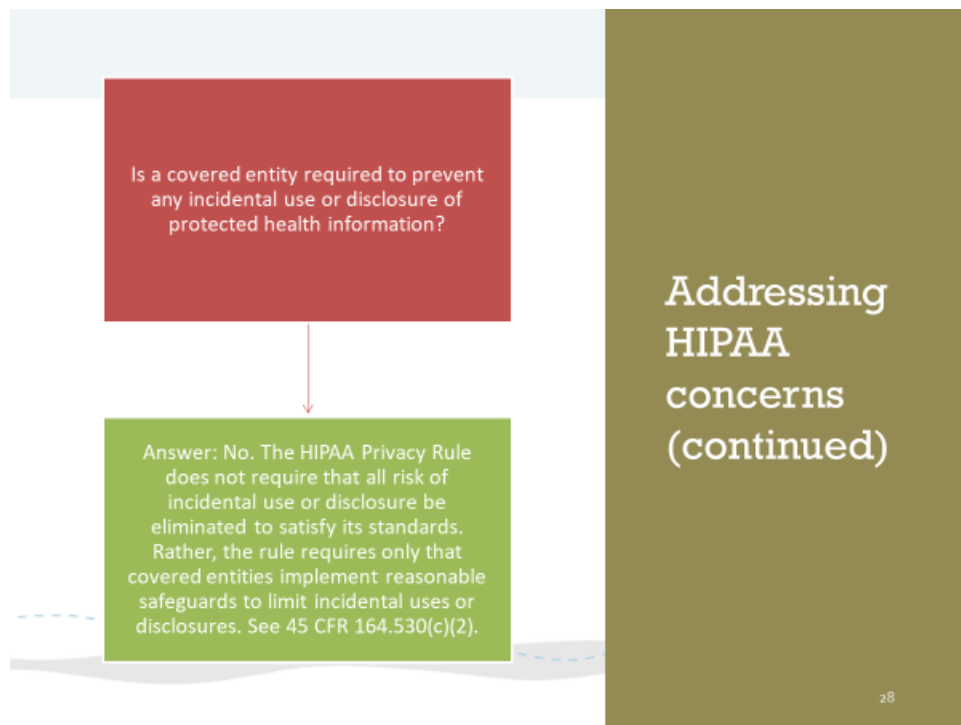
- Not involving the patient and family

- Not using whiteboard

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Next, we will discuss how HIPAA relates to bedside shift report because this may be a concern for the nurses.

Addressing HIPAA concerns
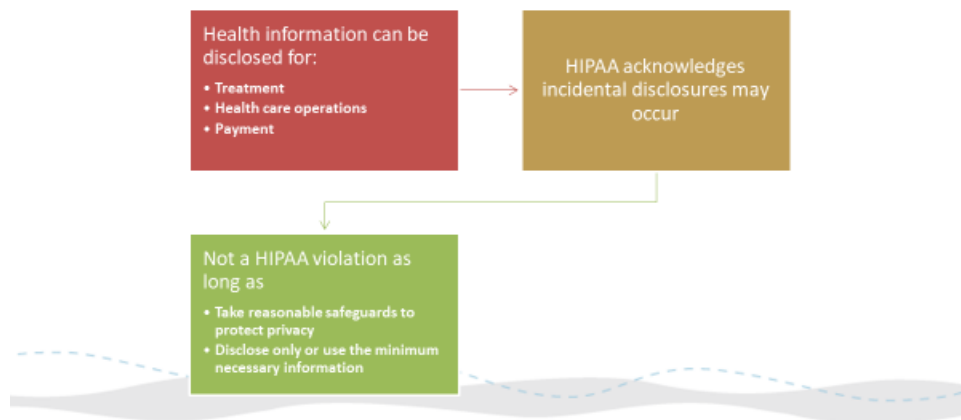
As nurses, you may be concerned about violating HIPAA, especially when family members are present at shift report or if you have patients in semiprivate rooms. It is important to know that because bedside shift report is part of treatment and normal operations, it does not violate HIPAA.
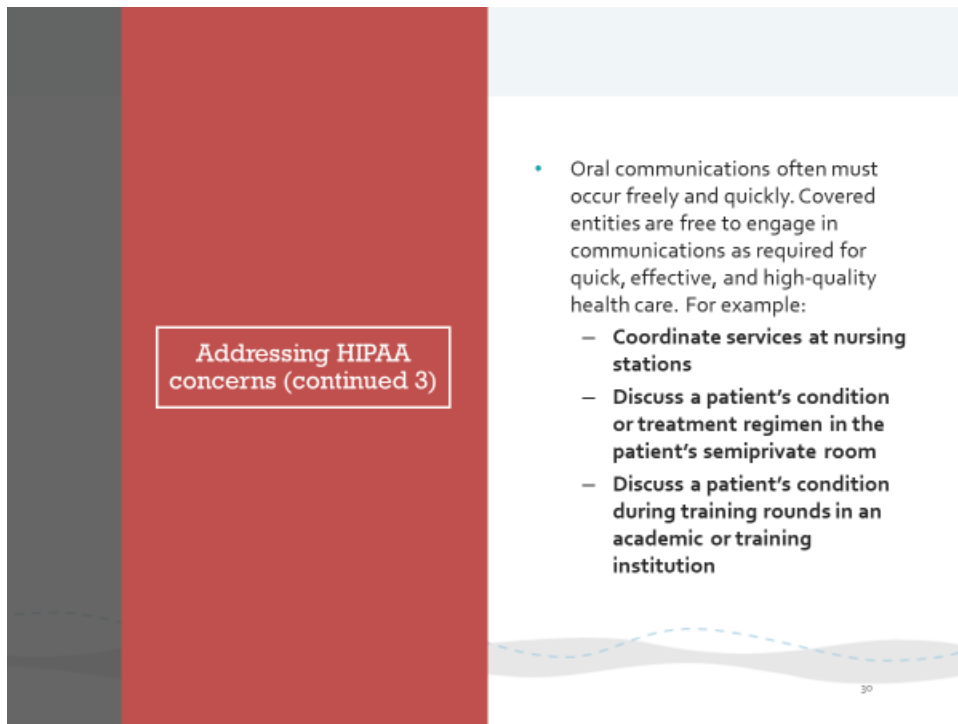
Is a covered entity required to prevent any incidental use or disclosure of protected health information?

Answer: No. The HIPAA Privacy Rule does not require that all risk of incidental use or disclosure be eliminated to satisfy its standards. Rather, the rule requires only that covered entities implement reasonable safeguards to limit incidental uses or disclosures. See 45 CFR 164.530(c)(2).

Addressing HIPAA concerns (continued)

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The HIPAA privacy rule recognizes that incidental disclosures might occur. Your responsibility is to ensure that you are making reasonable efforts to safeguard patient privacy.
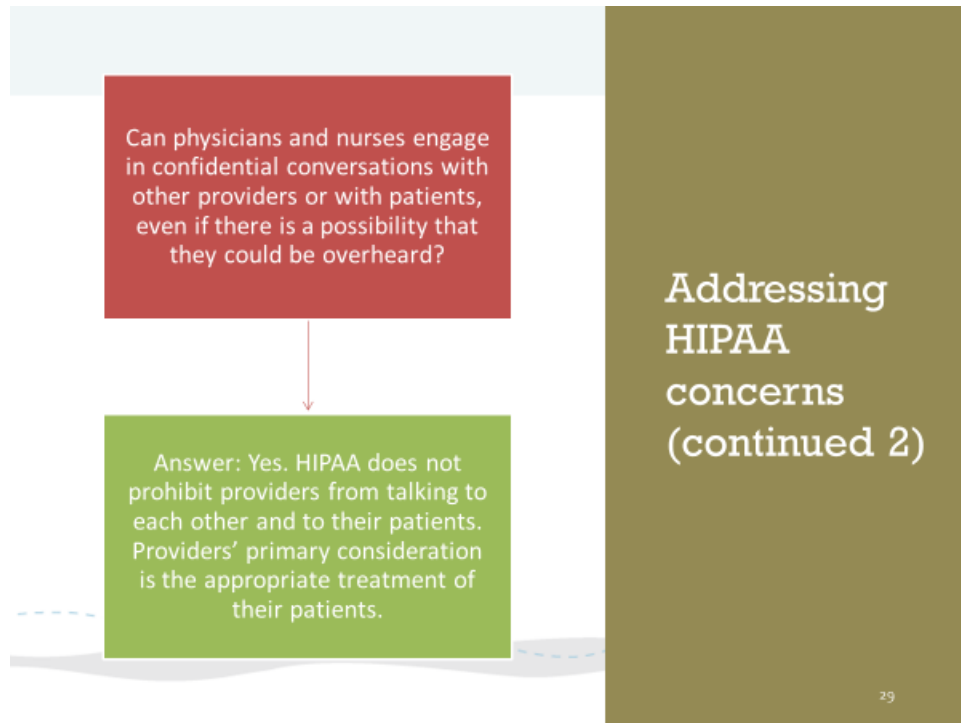
Can physicians and nurses engage in confidential conversations with other providers or with patients, even if there is a possibility that they could be overheard?

Yes. The HIPAA Privacy Rule is not intended to prohibit providers from talking to each other and to their patients. Provisions of this rule requiring covered entities to implement reasonable safeguards that reflect their particular circumstances and exempting treatment disclosures from certain requirements are intended to ensure that providers' primary consideration is the appropriate treatment of their patients.

The HIPAA Privacy Rule recognizes that oral communications often must occur freely and quickly in treatment settings. Thus, covered entities are free to engage in communications as required for quick, effective, and high-quality health care.

- Examples –
    - Health care staff may orally coordinate services at hospital nursing stations.
    - A physician may discuss a patient's condition or treatment regimen in the patient's semi-private room.
    - Healthcare professionals may discuss a patient's condition during training rounds in an academic or training institution.
- In these circumstances, reasonable precautions could include using lowered voices or talking apart from others when sharing protected health information.
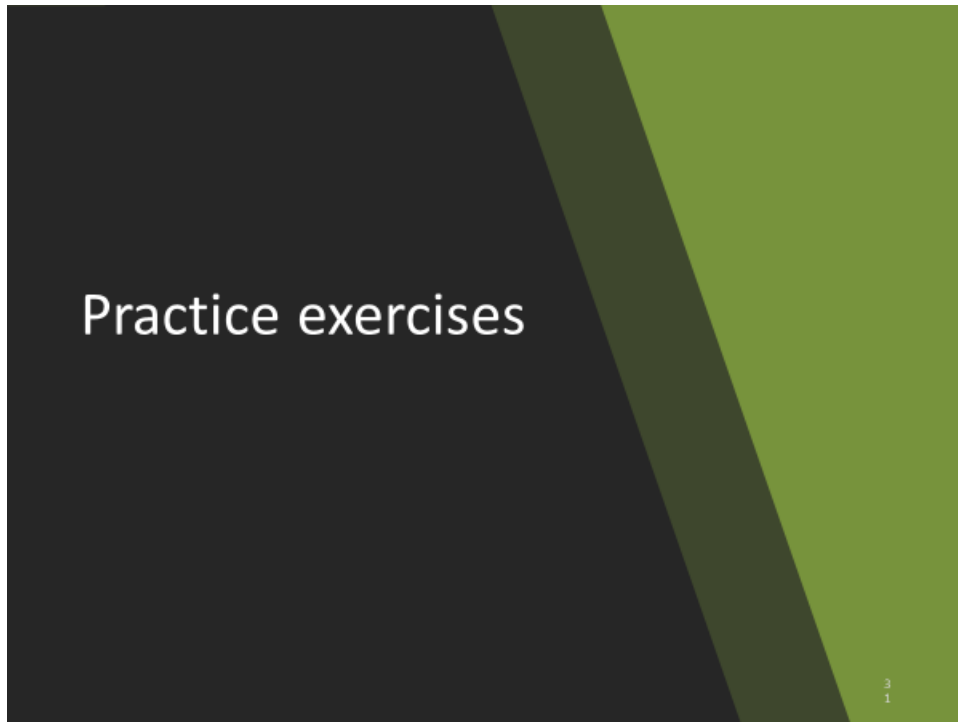
[*Note: There are a couple of options for practice exercises in this slide. You can do one or both, depending on the time available. Adapt the slides as needed.*]

Now, we have a practice exercise to get everyone comfortable doing bedside shift report. For this first exercise, let's break into groups of three.

Jack, a 64-year-old male with a history of chronic obstructive pulmonary disease, hypertension, and type 2 diabetes, was admitted to the unit this afternoon from the Emergency Department. His symptoms were severe morning headache with occasional vomiting for 3 days, chest pain, and shortness of breath. He received a dose of Zofran for vomiting before being brought up to the unit. During the initial nursing assessment, the nurse noticed a large bruise on his elbow and hip related to a recent fall.

It is time for evening shift change. During shift change, Jack notes he is slightly disoriented and drowsy and his headache has returned.
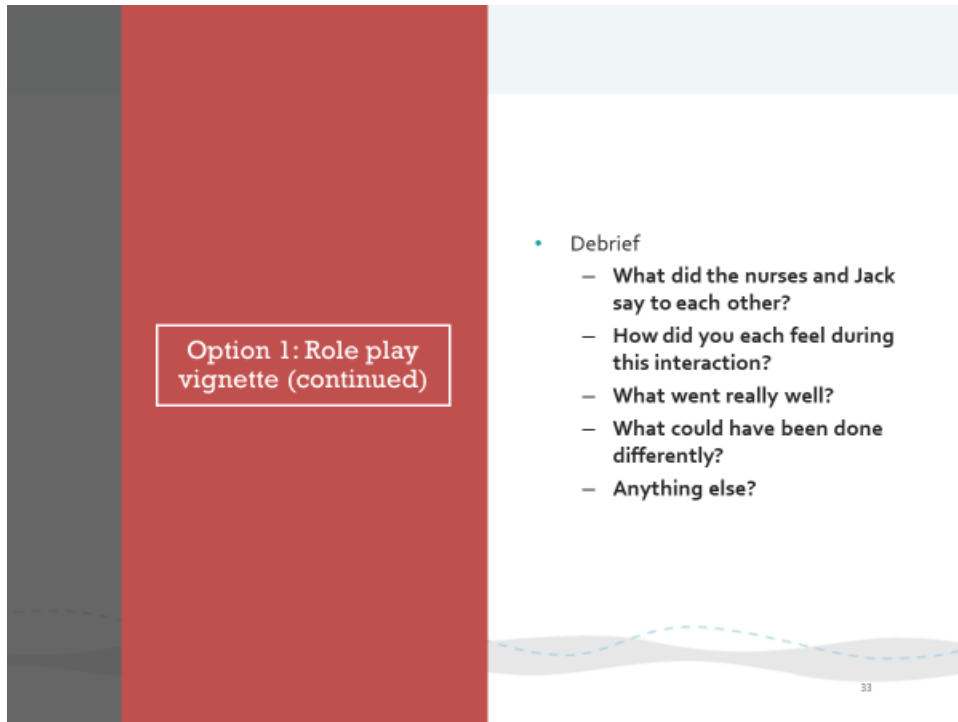
Option 1: Role play vignette

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[After people form groups, review the vignette. Tell the groups to assign the roles of a nurse coming on duty, a nurse going off duty, and patient. Provide these additional instructions.]
As you play out the scene, the objectives are to make sure that the two nurses complete the elements of the bedside shift report:

- Introduce the nursing staff, patient, and family.
- Invite the patient and family to participate
- Open medical record or electronic workstation in the patient's room
- Conduct a verbal SBAR report with the patient and family, using words they can understand
- Conduct a focused assessment of the patient (visually inspect all wounds, incisions, drains, IV sites and tubings, catheters, and so forth) and a safety assessment of the room (a visual sweep of the room for any physical safety concerns)
- Review tasks that need to be done, such as labs or tests needed, medications administered, forms that need to be completed, and so forth.
- Identify the patient and family's needs or concerns.
 Take 5 to 8 minutes for this exercise.

- Debrief
  - What did the nurses and Jack say to each other?
  - How did you each feel during this interaction?
  - What went really well?
  - What could have been done differently?
  - Anything else?

Option 1: Role play vignette (continued)

[*Get perspectives from different groups, summarize what the group overall said.*]

The presenter should make sure there is a group for each patient and family advisor at the training. Rotate through the room and help facilitate discussions as needed. After 10-15 minutes, ask the groups to report back to the larger group. Once you get perspectives from different groups, summarize what the group overall said. Reiterate the importance of bedside shift report.
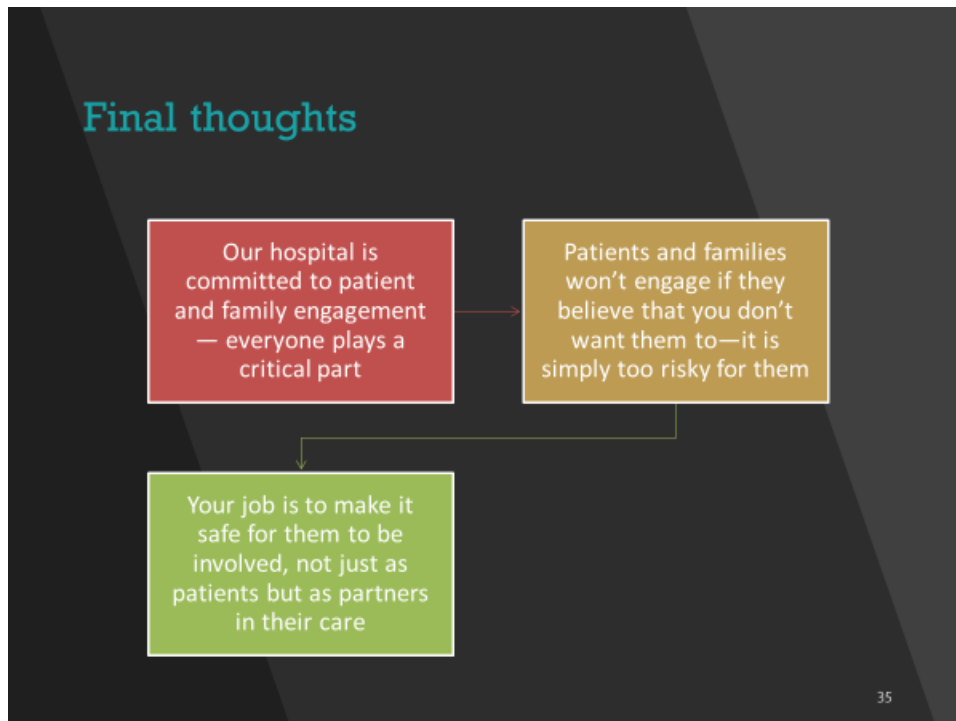
We would like to end by reiterating how important patient and family engagement is to our hospital. Clinicians and hospital staff play an important role in inviting and support patients and families as full partners in the healthcare team. By doing this, we can work together as partners to improve care experiences for everyone.
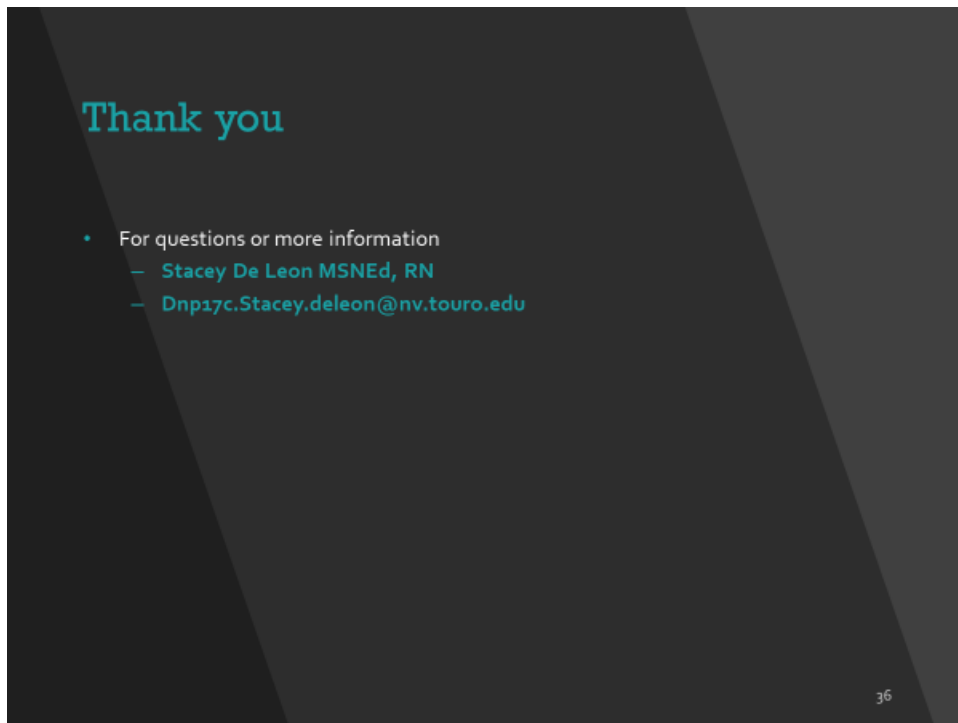
Thank you for your time today. If you would like additional information after this presentation, please feel free to contact me at any time.